

EXHIBIT C



Form 5500
Department of the Treasury
Internal Revenue Service
Department of Labor
Employee Benefits Security
Administration
Pension Benefit Guaranty Corporation

Annual Return/Report of Employee Benefit Plan

This form is required to be filed under sections 104 and 4065 of the
Employee Retirement Income Security Act of 1974 (ERISA) and
sections 6039D, 6047(e), 6057(b), and 6058(a) of the Internal
Revenue Code (the Code).

Complete all entries in accordance with
the instructions to the Form 5500.

Official Use Only
OMB Nos. 1210 - 0110
1210 - 0089
2008
This Form is Open to
Public Inspection

Part I Annual Report Identification Information

For the calendar plan year 2008 or fiscal plan year beginning May 01, 2008, and ending April 30, 2009

- A** This return/report is for:
- (1) ☒ a multiemployer plan;
- (2) ☐ a single-employer plan (other than a multiple-employer plan);
- (3) ☐ a multiple-employer plan;
- (4) ☐ a DFE (specify)
- B** This return/report is:
- (1) ☐ the first return/report filed for the plan;
- (2) ☐ the amended return/report;
- (3) ☐ the final return/report filed for the plan;
- (4) ☐ a short plan year return/report (less than 12 months).
- C** If the plan is a collectively-bargained plan, check here ☒
- D** If you filed for an extension of time to file, check the box and attach a copy of the extension application ☒

Part II Basic Plan Information - enter all requested information.

- 1a** Name of plan
BRICKLAYERS & ALLIED CRAFTWORKERS LOCAL 2 ALBANY, NY ANNUITY FUND
- 1b** Three-digit plan number (PN)
002
- 1c** Effective date of plan (mo., day, yr.)
July 01, 1987
- 2a** Plan sponsor's name and address (employer, if for a single-employer plan)
(Address should include room or suite no.)
BRICKLAYERS & ALLIED CRAFTWORKERS LOCAL 2 ALBANY, NY ANNUITY FUND
300 CENTRE DRIVE
ALBANY NY 12203-4474
- 2b** Employer Identification Number (EIN)
16-1298070
- 2c** Sponsor's telephone number
518-456-0259
- 2d** Business code (see instructions)
813930

Caution: A penalty for the late or incomplete filing of this return/report will be assessed unless reasonable cause is established. Under penalties of perjury and other penalties set forth in the instructions, I declare that I have examined this return/report, including accompanying schedules, statements and attachments, and to the best of my knowledge and belief, it is true, correct, and complete.

Signature of plan administrator
Date 11/26/1202
Typed or printed name of individual signing as plan administrator STEVEN J OSICK, PLAN ADMINISTRATOR

Signature of employer/plan sponsor/DFE
Date
Typed or printed name of individual signing as employer, plan sponsor or DFE as applicable BRICKLAYERS & ALLIED CRAFTWORKERS

For Paperwork Reduction Act Notice and OMB Control Numbers, see the instructions for Form 5500.

v11.3

Form 5500 (2008)

- 3a** Plan administrator's name and address (if same as plan sponsor, enter "Same")
SA14H
- 3b** Administrator's EIN
- 3c** Administrator's telephone number

- 4** If the name and/or EIN of the plan sponsor has changed since the last return/report filed for this plan, enter the name, EIN and the plan number from the last return/report below:
- a** Sponsor's name
- b** EIN
- c** PN

5 Preparer information (optional) a Name (including firm name, if applicable) and address

TRAL, BECKKK & CHIARAM014TE CPAS PC
7 WAAHINGTON SQUARLR
AT-BANY 12205

b EIN

14-1624930

c Telephone no.

518-456-6663

6 Total number of participants at the beginning of the plan year

1263

7 Number of participants as of the end of the plan year (welfare plans complete only lines 7a, 7b, 7c, and 7d)

a Active participants

1455

b Retired or separated participants receiving benefits

49

c Other retired or separated participants entitled to future benefits

d Subtotal. Add lines 7a, 7b, and 7c

1504

e Deceased participants whose beneficiaries are receiving or are entitled to receive benefits

11

f Total. Add lines 7d and 7e

1515

g Number of participants with account balances as of the end of the plan year (only defined contribution plans complete this item)

1515

h Number of participants that terminated employment during the plan year with accrued benefits that were less than 100% vested

i If any participant(s) separated from service with a deferred vested benefit, enter the number of separated participants required to be reported on a Schedule SSA (Form 5500)

8 Benefits provided under the plan (complete 8a through 8c, as applicable)

a ☒ Pension benefits (check this box if the plan provides pension benefits and enter the applicable pension feature codes from the List of Plan Characteristics Codes (printed in the instructions)):

2C 3B - - - - -

b ☐ Welfare benefits (check this box if the plan provides welfare benefits and enter the applicable welfare feature codes from the List of Plan Characteristics Codes (printed in the instructions)):

- - - - -

9a Plan funding arrangement (check all that apply)

(1) ☐ Insurance

(2) ☐ Section 412(e)(3) insurance contracts

(3) ☐ Trust

(4) ☐ General assets of the sponsor

9b Plan benefit arrangement (check all that apply)

(1) ☐ Insurance

(2) ☐ Section 412(e)(3) insurance contracts

(3) ☐ Trust

(4) ☐ General assets of the sponsor

10 Schedules attached (Check all applicable boxes and, where indicated, enter the number attached. See instructions.)

a Pension Benefit Schedules

(1) ☒ R (Retirement Plan Information)

(2) ☐ T (Qualified Pension Plan Coverage Information)

If a Schedule T is not attached because the plan is relying on coverage testing information for a prior year, enter the year

(3) ☐ B (Actuarial Information)

(4) ☐ E (ESOP Annual Information)

(5) ☐ SSA (Separated Vested participant Information)

b Financial Schedules

(1) ☒ H (Financial Information)

(2) ☐ I (Financial Information - Small Plan)

(3) ☒ 1 A (Insurance Information)

(4) ☒ C (Service Provider Information)

(5) ☒ D (DFE/Participating Plan Information)

(6) ☐ G (Financial Transaction Schedules)



Form 5500
Department of the Treasury
Internal Revenue Service
Department of Labor
Employee Benefits Security
Administration
Pension Benefit Guaranty Corporation

Annual Return/Report of Employee Benefit Plan

This form is required to be filed under sections 104 and 4065 of the Employee Retirement Income Security Act of 1974 (ERISA) and sections 6039D, 6047(e), 6057(b), and 6058(a) of the Internal Revenue Code (the Code).

Complete all entries in accordance with the instructions to the Form 5500.

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(2) ☐ a single-employer plan (other than a multiple-employer plan); (4) ☐ a DFE (specify)
- B This return/report is:
- (1) ☐ the first return/report filed for the plan; (3) ☐ the final return/report filed for the plan;
(2) ☐ the amended return/report; (4) ☐ a short plan year return/report (less than 12 months).
- C If the plan is a collectively-bargained plan, check here ☒
- D If you filed for an extension of time to file, check the box and attach a copy of the extension application ☒

Part II Basic Plan Information - enter all requested information.

- 1a Name of plan
BRICKLAYERS & ALLIED CRAFTWORKERS LOCAL 2 ALBANY, NY PENSION FUND
- 1b Three-digit plan number (PN) 001
- 1c Effective date of plan (mo., day, yr.)
May 01, 1963
- 2a Plan sponsor's name and address (employer, if for a single-employer plan)
(Address should include room or suite no.)
BRICKLAYERS & ALLIED CRAFTWORKERS LOCAL 2 ALBANY, NY PENSION FUND
300 CENTRE DRIVE
ALBANY NY 12203-4474
- 2b Employer Identification Number (EIN)
14-6075802
- 2c Sponsor's telephone number
518-456-0259
- 2d Business code (see instructions)
813930

Caution: A penalty for the late or incomplete filing of this return/report will be assessed unless reasonable cause is established. Under penalties of perjury and other penalties set forth in the instructions, I declare that I have examined this return/report, including accompanying schedules, statements and attachments, and to the best of my knowledge and belief, it is true, correct, and complete.

STEPHEN J OSICK, PLAN ADMINISTRATOR

Signature of plan administrator

Date

Typed or printed name of individual signing as plan administrator

BRICKLAYERS & ALLIED CRAFTWORKERS

Signature of employer/plan sponsor/DFE

Date

Typed or printed name of individual signing as employer, plan sponsor or DFE as applicable

For Paperwork Reduction Act Notice and OMB Control Numbers, see the instructions for Form 5500.

Form 5500 (2008)

v11.3

3a Plan administrator's name and address (if same as plan sponsor, enter "Same")

3b Administrator's EIN

3c Administrator's telephone number

SA14 R.

4 If the name and/or EIN of the plan sponsor has changed since the last return/report filed for this plan, enter the name, EIN and the plan number from the last return/report below:

b EIN

c PN

a Sponsor's name

5 Preparer information (optional) a Name (including firm name, if applicable) and address

TKAT., BECKER & CHIARAMONTE CPA-Q P KMVIN B. TULLY, CPA
7 WASHINGTON SQUAPR
ALBANY 12205

b EIN

14-1624930

c Telephone no.

518-456-6663

6 Total number of participants at the beginning of the plan year

6 1696

7 Number of participants as of the end of the plan year (welfare plans complete only lines 7a, 7b, 7c, and 7d)

a Active participants

a 915

b Retired or separated participants receiving benefits

b 511

c Other retired or separated participants entitled to future benefits

c 231

d Subtotal. Add lines 7a, 7b, and 7c

d 1657

e Deceased participants whose beneficiaries are receiving or are entitled to receive benefits

e 86

f Total. Add lines 7d and 7e

f 1743

g Number of participants with account balances as of the end of the plan year (only defined contribution plans complete this item)

g

h Number of participants that terminated employment during the plan year with accrued benefits that were less than 100% vested

h 45

i If any participant(s) separated from service with a deferred vested benefit, enter the number of separated participants required to be reported on a Schedule SSA (Form 5500)

i 25

8 Benefits provided under the plan (complete 8a through 8c, as applicable)

a ☒ **Pension benefits** (check this box if the plan provides pension benefits and enter the applicable pension feature codes from the List of Plan Characteristics Codes (printed in the instructions));

b ☐ **Welfare benefits** (check this box if the plan provides welfare benefits and enter the applicable welfare feature codes from the List of Plan Characteristics Codes (printed in the instructions));

9a Plan funding arrangement (check all that apply)

- (1) ☐ Insurance
(2) ☐ Section 412(e)(3) insurance contracts
(3) ☐ Trust
(4) ☐ General assets of the sponsor

9b Plan benefit arrangement (check all that apply)

- (1) ☐ Insurance
(2) ☐ Section 412(e)(3) insurance contracts
(3) ☐ Trust
(4) ☐ General assets of the sponsor

10 Schedules attached (Check all applicable boxes and, where indicated, enter the number attached. See instructions.)

a Pension Benefit Schedules

- (1) ☒ **R** (Retirement Plan Information)
(2) ☐ **OT** (Qualified Pension Plan Coverage Information)

If a Schedule T is not attached because the plan is relying on coverage testing information for a prior year, enter the year

- (3) ☐ **B** (Actuarial Information)
(4) ☐ **E** (ESOP Annual Information)
(5) ☐ **SSA** (Separated Vested participant Information)

b Financial Schedules

- (1) ☒ **H** (Financial Information)
(2) ☐ **I** (Financial Information – Small Plan)
(3) ☐ **0 A** (Insurance Information)
(4) ☒ **C** (Service Provider Information)
(5) ☒ **D** (DFE/Participating Plan Information)
(6) ☐ **G** (Financial Transaction Schedules)



Form 5500
Department of the Treasury
Internal Revenue Service
Department of Labor
Employee Benefits Security
Administration
Pension Benefit Guaranty Corporation

Annual Return/Report of Employee Benefit Plan

This form is required to be filed under sections 104 and 4065 of the
Employee Retirement Income Security Act of 1974 (ERISA) and
sections 6039D, 6047(e), 6057(b), and 6058(a) of the Internal
Revenue Code (the Code).

Complete all entries in accordance with
the instructions to the Form 5500.

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OMB Nos. 1210 - 0110
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Part I Annual Report Identification Information

For the calendar plan year 2008 or fiscal plan year beginning July 01, 2008, and ending June 30, 2009

- A** This return/report is for:
- (1) ☒ a multiemployer plan; (3) ☐ a multiple-employer plan;
(2) ☐ a single-employer plan (other than a multiple-employer plan); (4) ☐ a DFE (specify)
- B** This return/report is:
- (1) ☐ the first return/report filed for the plan; (3) ☐ the final return/report filed for the plan;
(2) ☐ the amended return/report; (4) ☐ a short plan year return/report (less than 12 months).
- C** If the plan is a collectively-bargained plan, check here ☒
- D** If you filed for an extension of time to file, check the box and attach a copy of the extension application ☐

Part II Basic Plan Information - enter all requested information.

- 1a** Name of plan
ONONDAGA COUNTY LABORERS ANNUITY FUND
- 1b** Three-digit plan number (PN) 002
- 1c** Effective date of plan (mo., day, yr.)
April 01, 1984
- 2a** Plan sponsor's name and address (employer, if for a single-employer plan)
(Address should include room or suite no.)
ONONDAGA COUNTY LABORERS ANNUITY FUND BOARD OF TRUSTEES
7051 FLY ROAD
EAST SYRACUSE NY 13057-9659
- 2b** Employer Identification Number (EIN)
16-1229376
- 2c** Sponsor's telephone number
315-434-9305
- 2d** Business code (see instructions)
525100

Caution: A penalty for the late or incomplete filing of this return/report will be assessed unless reasonable cause is established. Under penalties of perjury and other penalties set forth in the instructions, I declare that I have examined this return/report, including accompanying schedules, statements and attachments, and to the best of my knowledge and belief, it is true, correct, and complete.

GABRIEL ROSETTI, III

Signature of plan administrator

Date

Typed or printed name of individual signing as plan administrator

EARL R. HALL

Signature of employer/plan sponsor/DFE

Date

Typed or printed name of individual signing as employer, plan sponsor or DFE as applicable

For Paperwork Reduction Act Notice and OMB Control Numbers, see the instructions for Form 5500.

Form 5500 (2008)

v11.3

3a Plan administrator's name and address (if same as plan sponsor, enter "Same")

3b Administrator's EIN

3c Administrator's telephone number

SAME

4 If the name and/or EIN of the plan sponsor has changed since the last return/report filed for this plan, enter the name, EIN and the plan number from the last return/report below:

b EIN

a Sponsor's name

c PN

5 Preparer information (optional) **a** Name (including firm name, if applicable) and address

RICHARD W. HEIMERMAN, CPA P.C.
290 ELWOOD DAVIS ROAD, SUITE 280
LIVERPOOL NY 13088-0000

b EIN

16-1537589

c Telephone no.

315-451-9771

6 Total number of participants at the beginning of the plan year

492

7 Number of participants as of the end of the plan year (welfare plans complete only lines **7a**, **7b**, **7c**, and **7d**)

a Active participants

a 529

b Retired or separated participants receiving benefits

b 19

c Other retired or separated participants entitled to future benefits

c 285

d Subtotal. Add lines **7a**, **7b**, and **7c**

d 833

e Deceased participants whose beneficiaries are receiving or are entitled to receive benefits

e 19

f Total. Add lines **7d** and **7e**

f 852

g Number of participants with account balances as of the end of the plan year (only defined contribution plans complete this item)

g 852

h Number of participants that terminated employment during the plan year with accrued benefits that were less than 100% vested

h

i If any participant(s) separated from service with a deferred vested benefit, enter the number of separated participants required to be reported on a Schedule SSA (Form 5500)

i 17

8 Benefits provided under the plan (complete 8a through 8c, as applicable)

a ☒ **Pension benefits** (check this box if the plan provides pension benefits and enter the applicable pension feature codes from the List of Plan Characteristics Codes (printed in the instructions)):

2E - - - - -

b ☐ **Welfare benefits** (check this box if the plan provides welfare benefits and enter the applicable welfare feature codes from the List of Plan Characteristics Codes (printed in the instructions)):

- - - - -

9a Plan funding arrangement (check all that apply)

- (1) ☐ Insurance
(2) ☐ Section 412(e)(3) insurance contracts
(3) ☐ Trust
(4) ☐ General assets of the sponsor

9b Plan benefit arrangement (check all that apply)

- (1) ☐ Insurance
(2) ☐ Section 412(e)(3) insurance contracts
(3) ☐ Trust
(4) ☐ General assets of the sponsor

10 Schedules attached (Check all applicable boxes and, where indicated, enter the number attached. See instructions.)

a **Pension Benefit Schedules**

- (1) ☐ **R** (Retirement Plan Information)
(2) ☐ **T** (Qualified Pension Plan Coverage Information)

If a Schedule T is not attached because the plan is relying on coverage testing information for a prior year, enter the year

- (3) ☐ **B** (Actuarial Information)
(4) ☐ **E** (ESOP Annual Information)
(5) ☒ **SSA** (Separated Vested participant Information)

b **Financial Schedules**

- (1) ☒ **H** (Financial Information)
(2) ☐ **I** (Financial Information – Small Plan)
(3) ☒ **1 A** (Insurance Information)
(4) ☒ **C** (Service Provider Information)
(5) ☒ **D** (DFE/Participating Plan Information)
(6) ☐ **G** (Financial Transaction Schedules)



Form 5500
Department of the Treasury
Internal Revenue Service
Department of Labor
Employee Benefits Security
Administration
Pension Benefit Guaranty Corporation

Annual Return/Report of Employee Benefit Plan

This form is required to be filed under sections 104 and 4065 of the Employee Retirement Income Security Act of 1974 (ERISA) and sections 6039D, 6047(e), 6057(b), and 6058(a) of the Internal Revenue Code (the Code).

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(2) ☐ a single-employer plan (other than a multiple-employer plan); (4) ☐ a DFE (specify)
- B** This return/report is:
- (1) ☐ the first return/report filed for the plan; (3) ☐ the final return/report filed for the plan;
(2) ☐ the amended return/report; (4) ☐ a short plan year return/report (less than 12 months).
- C** If the plan is a collectively-bargained plan, check here ☒
- D** If you filed for an extension of time to file, check the box and attach a copy of the extension application ☒

Part II Basic Plan Information - enter all requested information.

1a Name of plan

CENTRAL NEW YORK LABORERS PENSION FUND

1b Three-digit plan number (PN) 001

1c Effective date of plan (mo., day, yr.)
January 05, 1960

2a Plan sponsor's name and address (employer, if for a single-employer plan) (Address should include room or suite no.)

CENTRAL NEW YORK LABORERS PENSION FUND BOARD OF TRUSTEES
7051 FLY ROAD
EAST SYRACUSE NY 13057-9659

2b Employer Identification Number (EIN)
15-6016579

2c Sponsor's telephone number
315-434-9305

2d Business code (see instructions)
525100

Caution: A penalty for the late or incomplete filing of this return/report will be assessed unless reasonable cause is established. Under penalties of perjury and other penalties set forth in the instructions, I declare that I have examined this return/report, including accompanying schedules, statements and attachments, and to the best of my knowledge and belief, it is true, correct, and complete.

GABRIEL M. ROSETTI, III

Signature of plan administrator

Date

Typed or printed name of individual signing as plan administrator

EARL R. HALL

Signature of employer/plan sponsor/DFE

Date

Typed or printed name of individual signing as employer, plan sponsor or DFE as applicable

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Form 5500 (2008)

v11.3

3a Plan administrator's name and address (if same as plan sponsor, enter "Same")

SAME

3b Administrator's EIN

3c Administrator's telephone number

4 If the name and/or EIN of the plan sponsor has changed since the last return/report filed for this plan, enter the name, EIN and the plan number from the last return/report below:

b EIN

a Sponsor's name

c PN

5 Preparer information (optional) a Name (including firm name, if applicable) and address

RICHARD W. HEIMERMAN, CPA P.C.
290 ELWOOD DAVIS ROAD, SUITE 280
LIVERPOOL NY 13088-0000

b EIN

16-1537589

c Telephone no.

315-451-9771

6 Total number of participants at the beginning of the plan year

677

7 Number of participants as of the end of the plan year (welfare plans complete only lines 7a, 7b, 7c, and 7d)

a Active participants

219

b Retired or separated participants receiving benefits

281

c Other retired or separated participants entitled to future benefits

100

d Subtotal. Add lines 7a, 7b, and 7c

600

e Deceased participants whose beneficiaries are receiving or are entitled to receive benefits

74

f Total. Add lines 7d and 7e

674

g Number of participants with account balances as of the end of the plan year (only defined contribution plans complete this item)

g

h Number of participants that terminated employment during the plan year with accrued benefits that were less than 100% vested

h

i If any participant(s) separated from service with a deferred vested benefit, enter the number of separated participants required to be reported on a Schedule SSA (Form 5500)

i 7

8 Benefits provided under the plan (complete 8a through 8c, as applicable)

- a ☒ **Pension benefits** (check this box if the plan provides pension benefits and enter the applicable pension feature codes from the List of Plan Characteristics Codes (printed in the instructions)):

1B 1G - - - - -

- b ☐ **Welfare benefits** (check this box if the plan provides welfare benefits and enter the applicable welfare feature codes from the List of Plan Characteristics Codes (printed in the instructions)):

- - - - -

9a Plan funding arrangement (check all that apply)

- (1) ☐ Insurance
(2) ☐ Section 412(e)(3) insurance contracts
(3) ☐ Trust
(4) ☐ General assets of the sponsor

9b Plan benefit arrangement (check all that apply)

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(2) ☐ Section 412(e)(3) insurance contracts
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- (1) ☒ R (Retirement Plan Information)
(2) ☐ OT (Qualified Pension Plan Coverage Information)

If a Schedule T is not attached because the plan is relying on coverage testing information for a prior year, enter the year

- (3) ☒ B (Actuarial Information)
(4) ☐ E (ESOP Annual Information)
(5) ☒ SSA (Separated Vested participant Information)

b Financial Schedules

- (1) ☒ H (Financial Information)
(2) ☐ I (Financial Information - Small Plan)
(3) ☐ A (Insurance Information)
(4) ☒ C (Service Provider Information)
(5) ☒ D (DFE/Participating Plan Information)
(6) ☐ G (Financial Transaction Schedules)



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- C** If the plan is a collectively-bargained plan, check here ☒
- D** If you filed for an extension of time to file, check the box and attach a copy of the extension application ☒

Part II Basic Plan Information - enter all requested information.

1a Name of plan

IBEW LOCAL 43 & ELECTRICAL CONTRACTORS PENSION FUND

1b Three-digit plan number (PN) 001

1c Effective date of plan (mo., day, yr.)
July 01, 1962

2a Plan sponsor's name and address (employer, if for a single-employer plan) (Address should include room or suite no.)

IBEW LOCAL 43 & ELECTRICAL CONTRACTORS PENSION FUND
PO BOX 2218
SYRACUSE NY 13220-2218

2b Employer Identification Number (EIN)
16-6153389

2c Sponsor's telephone number
315-474-5729

2d Business code (see instructions)
238210

Caution: A penalty for the late or incomplete filing of this return/report will be assessed unless reasonable cause is established.

Under penalties of perjury and other penalties set forth in the instructions, I declare that I have examined this return/report, including accompanying schedules, statements and attachments, and to the best of my knowledge and belief, it is true, correct, and complete.

Signature of plan administrator

Date

Typed or printed name of individual signing as plan administrator

HILLIPLLYP P .1"PEU);50^K,C

Signature of employer/plan sponsor/DFE

Date

Typed or printed name of individual signing as employer, plan sponsor or DFE as applicable

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Form 5500 (2008)

v11.3

3a Plan administrator's name and address (if same as plan sponsor, enter "Same")

SAME

3b Administrator's EIN
16-6153389

3c Administrator's telephone number

4 If the name and/or EIN of the plan sponsor has changed since the last return/report filed for this plan, enter the name, EIN and the plan number from the last return/report below:

b EIN

c PN

a Sponsor's name

5 Preparer information (optional) **a** Name (including firm name, if applicable) and address

PARENTEBEARD I.T.C THOMAS E. RILEY
115 SOLAR ST 100
SYRACUSE N 13204

b EIN

23-2932984

c Telephone no.

154712777

6 Total number of participants at the beginning of the plan year

1601

7 Number of participants as of the end of the plan year (welfare plans complete only lines **7a**, **7b**, **7c**, and **7d**)

a Active participants

850

b Retired or separated participants receiving benefits

478

c Other retired or separated participants entitled to future benefits

250

d Subtotal. Add lines **7a**, **7b**, and **7c**

1578

e Deceased participants whose beneficiaries are receiving or are entitled to receive benefits

86

f Total. Add lines **7d** and **7e**

1664

g Number of participants with account balances as of the end of the plan year (only defined contribution plans complete this item)

h Number of participants that terminated employment during the plan year with accrued benefits that were less than 100% vested

14

i If any participant(s) separated from service with a deferred vested benefit, enter the number of separated participants required to be reported on a Schedule SSA (Form 5500)

11

8 Benefits provided under the plan (complete 8a through 8c, as applicable)

a ☒ **Pension benefits** (check this box if the plan provides pension benefits and enter the applicable pension feature codes from the List of Plan Characteristics Codes (printed in the instructions)):

b ☐ **Welfare benefits** (check this box if the plan provides welfare benefits and enter the applicable welfare feature codes from the List of Plan Characteristics Codes (printed in the instructions)):

9a Plan funding arrangement (check all that apply)

- (1) ☐ Insurance
(2) ☐ Section 412(e)(3) insurance contracts
(3) ☐ Trust
(4) ☐ General assets of the sponsor

9b Plan benefit arrangement (check all that apply)

- (1) ☐ Insurance
(2) ☐ Section 412(e)(3) insurance contracts
(3) ☐ Trust
(4) ☐ General assets of the sponsor

10 Schedules attached (Check all applicable boxes and, where indicated, enter the number attached. See instructions.)

a **Pension Benefit Schedules**

- (1) ☒ **R** (Retirement Plan Information)
(2) ☐ **OT** (Qualified Pension Plan Coverage Information)

If a Schedule T is not attached because the plan is relying on coverage testing information for a prior year, enter the year

- (3) ☒ **B** (Actuarial Information)
(4) ☐ **E** (ESOP Annual Information)
(5) ☒ **SSA** (Separated Vested participant Information)

b **Financial Schedules**

- (1) ☒ **H** (Financial Information)
(2) ☐ **I** (Financial Information – Small Plan)
(3) ☐ **0 A** (Insurance Information)
(4) ☒ **C** (Service Provider Information)
(5) ☒ **D** (DFE/Participating Plan Information)
(6) ☐ **G** (Financial Transaction Schedules)



Form 5500
Department of the Treasury
Internal Revenue Service
Department of Labor
Employee Benefits Security
Administration
Pension Benefit Guaranty Corporation

Annual Return/Report of Employee Benefit Plan

This form is required to be filed under sections 104 and 4065 of the Employee Retirement Income Security Act of 1974 (ERISA) and sections 6039D, 6047(e), 6057(b), and 6058(a) of the Internal Revenue Code (the Code).

Complete all entries in accordance with the instructions to the Form 5500.

Official Use Only
OMB Nos. 1210 - 0110
1210 - 0089
2008

This Form is Open to
Public Inspection

Part I Annual Report Identification Information

For the calendar plan year 2008 or fiscal plan year beginning July 01, 2008, and ending June 30, 2009

- A** This return/report is for:
- (1) ☒ a multiemployer plan; (3) ☐ a multiple-employer plan;
(2) ☐ a single-employer plan (other than a multiple-employer plan); (4) ☐ a DFE (specify)
- B** This return/report is:
- (1) ☐ the first return/report filed for the plan; (3) ☐ the final return/report filed for the plan;
(2) ☐ the amended return/report; (4) ☐ a short plan year return/report (less than 12 months).
- C** If the plan is a collectively-bargained plan, check here ☒
- D** If you filed for an extension of time to file, check the box and attach a copy of the extension application ☐

Part II Basic Plan Information - enter all requested information.

1a Name of plan

I.B.E.W. LOCAL 139 PENSION PLAN

1b Three-digit plan number (PN) 001

1c Effective date of plan (mo., day, yr.)
July 01, 1961

2a Plan sponsor's name and address (employer, if for a single-employer plan) (Address should include room or suite no.)

IBEW LOCAL 139 PENSION FUND BOARD OF TRUSTEES
508 COLLEGE AVENUE
ELMIRA NY 14901-2416

2b Employer Identification Number (EIN)
51-6029960

2c Sponsor's telephone number
607-732-1237

2d Business code (see instructions)
238210

Caution: A penalty for the late or incomplete filing of this return/report will be assessed unless reasonable cause is established. Under penalties of perjury and other penalties set forth in the instructions, I declare that I have examined this return/report, including accompanying schedules, statements and attachments, and to the best of my knowledge and belief, it is true, correct, and complete.

ORLRIV A - 00R40 AA,,

Signature of plan administrator

Date

Typed or printed name of individual signing as plan administrator

IBEW LOCAL 139 PENSION FUND

Signature of employer/plan sponsor/DFE

Date

Typed or printed name of individual signing as employer, plan sponsor or DFE as applicable

For Paperwork Reduction Act Notice and OMB Control Numbers, see the instructions for Form 5500.

Form 5500 (2008)

v11.3

3a Plan administrator's name and address (if same as plan sponsor, enter "Same")

SP

3b Administrator's EIN

3c Administrator's telephone number

4 If the name and/or EIN of the plan sponsor has changed since the last return/report filed for this plan, enter the name, EIN and the plan number from the last return/report below:

b EIN

c PN

a Sponsor's name

5 Preparer information (optional) a Name (including firm name, if applicable) and address

b EIN

c Telephone no.

6 Total number of participants at the beginning of the plan year

6 348

7 Number of participants as of the end of the plan year (welfare plans complete only lines 7a, 7b, 7c, and 7d)

a Active participants

a 213

b Retired or separated participants receiving benefits

b 86

c Other retired or separated participants entitled to future benefits

c 29

d Subtotal. Add lines 7a, 7b, and 7c

d 328

e Deceased participants whose beneficiaries are receiving or are entitled to receive benefits

e 19

f Total. Add lines 7d and 7e

f 347

g Number of participants with account balances as of the end of the plan year (only defined contribution plans complete this item)

g

h Number of participants that terminated employment during the plan year with accrued benefits that were less than 100% vested

h

i If any participant(s) separated from service with a deferred vested benefit, enter the number of separated participants required to be reported on a Schedule SSA (Form 5500)

i

8 Benefits provided under the plan (complete 8a through 8c, as applicable)

a ☒ Pension benefits (check this box if the plan provides pension benefits and enter the applicable pension feature codes from the List of Plan Characteristics Codes (printed in the instructions)):

1B - - - - -

b ☐ Welfare benefits (check this box if the plan provides welfare benefits and enter the applicable welfare feature codes from the List of Plan Characteristics Codes (printed in the instructions)):

- - - - -

9a Plan funding arrangement (check all that apply)

(1) ☐ Insurance

(2) ☐ Section 412(e)(3) insurance contracts

(3) ☐ Trust

(4) ☐ General assets of the sponsor

9b Plan benefit arrangement (check all that apply)

(1) ☐ Insurance

(2) ☐ Section 412(e)(3) insurance contracts

(3) ☐ Trust

(4) ☐ General assets of the sponsor

10 Schedules attached (Check all applicable boxes and, where indicated, enter the number attached. See instructions.)

a Pension Benefit Schedules

(1) ☒ R (Retirement Plan Information)

(2) ☐ OT (Qualified Pension Plan Coverage Information)

If a Schedule T is not attached because the plan is relying on coverage testing information for a prior year, enter the year

(3) ☒ B (Actuarial Information)

(4) ☐ E (ESOP Annual Information)

(5) ☐ SSA (Separated Vested participant Information)

b Financial Schedules

(1) ☒ H (Financial Information)

(2) ☐ I (Financial Information – Small Plan)

(3) ☒ 1 A (Insurance Information)

(4) ☒ C (Service Provider Information)

(5) ☒ D (DFE/Participating Plan Information)

(6) ☐ G (Financial Transaction Schedules)



Form 5500
Department of the Treasury
Internal Revenue Service
Department of Labor
Employee Benefits Security
Administration
Pension Benefit Guaranty Corporation

Annual Return/Report of Employee Benefit Plan

This form is required to be filed under sections 104 and 4065 of the Employee Retirement Income Security Act of 1974 (ERISA) and sections 6039D, 6047(e), 6057(b), and 6058(a) of the Internal Revenue Code (the Code).

Complete all entries in accordance with the instructions to the Form 5500.

Official Use Only
OMB Nos. 1210 - 0110
1210 - 0089
2008
This Form is Open to
Public Inspection

Part I Annual Report Identification Information

For the calendar plan year 2008 or fiscal plan year beginning June 01, 2008, and ending May 31, 2009

- A** This return/report is for:
- (1) ☒ a multiemployer plan;
- (2) ☐ a single-employer plan (other than a multiple-employer plan);
- (3) ☐ a multiple-employer plan;
- (4) ☐ a DFE (specify)
- B** This return/report is:
- (1) ☐ the first return/report filed for the plan;
- (2) ☐ the amended return/report;
- (3) ☐ the final return/report filed for the plan;
- (4) ☐ a short plan year return/report (less than 12 months).
- C** If the plan is a collectively-bargained plan, check here ☒
- D** If you filed for an extension of time to file, check the box and attach a copy of the extension application ☒

Part II Basic Plan Information – enter all requested information.

1a Name of plan

LOCAL 241 OF THE INTERNATIONAL BROTHERHOOD OF ELECTRICAL WORKERS
PENSION PLAN

1b Three-digit plan number (PN) 001

1c Effective date of plan (mo., day, yr.) June 01, 1964

2a Plan sponsor's name and address (employer, if for a single-employer plan) (Address should include room or suite no.)

LOCAL 241 OF THE I.B.E.W.
701 W. STATE STREET
ITHACA NY 14850-3309

2b Employer Identification Number (EIN) 16-6118689

2c Sponsor's telephone number 607-272-2809

2d Business code (see instructions) 238210

Caution: A penalty for the late or incomplete filing of this return/report will be assessed unless reasonable cause is established. Under penalties of perjury and other penalties set forth in the instructions, I declare that I have examined this return/report, including accompanying schedules, statements and attachments, and to the best of my knowledge and belief, it is true, correct, and complete.

Signature of plan administrator

Date

Typed or printed name of individual signing as plan administrator

03/12/2010

Signature of employer/plan sponsor/DFE

Date

Typed or printed name of individual signing as employer, plan sponsor or DFE as applicable

For Paperwork Reduction Act Notice and OMB Control Numbers, see the instructions for Form 5500.

v11.3

Form 5500 (2008)

3a Plan administrator's name and address (if same as plan sponsor, enter "Same")

SAME

3b Administrator's EIN

3c Administrator's telephone number

4 If the name and/or EIN of the plan sponsor has changed since the last return/report filed for this plan, enter the name, EIN and the plan number from the last return/report below:

b EIN

c PN

a Sponsor's name

5 Preparer information (optional) **a** Name (including firm name, if applicable) and address

CDT.M & COMPANY CPAR, LLP PAI.RXI(K JORNAN
401 E STATE STIT 500
ITHARA 14890

b EIN

16-1171627

c Telephone no.
607-272-4444

6 Total number of participants at the beginning of the plan year

173

7 Number of participants as of the end of the plan year (welfare plans complete only lines **7a**, **7b**, **7c**, and **7d**)

a Active participants

153

b Retired or separated participants receiving benefits

29

c Other retired or separated participants entitled to future benefits

15

d Subtotal. Add lines **7a**, **7b**, and **7c**

197

e Deceased participants whose beneficiaries are receiving or are entitled to receive benefits

2

f Total. Add lines **7d** and **7e**

199

g Number of participants with account balances as of the end of the plan year (only defined contribution plans complete this item)

h Number of participants that terminated employment during the plan year with accrued benefits that were less than 100% vested

i If any participant(s) separated from service with a deferred vested benefit, enter the number of separated participants required to be reported on a Schedule SSA (Form 5500)

4

8 Benefits provided under the plan (complete 8a through 8c, as applicable)

a ☒ **Pension benefits** (check this box if the plan provides pension benefits and enter the applicable pension feature codes from the List of Plan Characteristics Codes (printed in the instructions)):

b ☐ **Welfare benefits** (check this box if the plan provides welfare benefits and enter the applicable welfare feature codes from the List of Plan Characteristics Codes (printed in the instructions)):

9a Plan funding arrangement (check all that apply)

- (1) ☐ Insurance
(2) ☐ Section 412(e)(3) insurance contracts
(3) ☐ Trust
(4) ☐ General assets of the sponsor

9b Plan benefit arrangement (check all that apply)

- (1) ☐ Insurance
(2) ☐ Section 412(e)(3) insurance contracts
(3) ☐ Trust
(4) ☐ General assets of the sponsor

10 Schedules attached (Check all applicable boxes and, where indicated, enter the number attached. See instructions.)

a **Pension Benefit Schedules**

- (1) ☒ **R** (Retirement Plan Information)
(2) ☐ **OT** (Qualified Pension Plan Coverage Information)

If a Schedule T is not attached because the plan is relying on coverage testing information for a prior year, enter the year

- (3) ☒ **B** (Actuarial Information)
(4) ☐ **E** (ESOP Annual Information)
(5) ☒ **SSA** (Separated Vested participant Information)

b **Financial Schedules**

- (1) ☒ **H** (Financial Information)
(2) ☐ **I** (Financial Information – Small Plan)
(3) ☐ **0 A** (Insurance Information)
(4) ☒ **C** (Service Provider Information)
(5) ☒ **D** (DFE/Participating Plan Information)
(6) ☐ **G** (Financial Transaction Schedules)



Form 5500
Department of the Treasury
Internal Revenue Service
Department of Labor
Employee Benefits Security
Administration
Pension Benefit Guaranty Corporation

Annual Return/Report of Employee Benefit Plan

This form is required to be filed under sections 104 and 4065 of the
Employee Retirement Income Security Act of 1974 (ERISA) and
sections 6039D, 6047(e), 6057(b), and 6058(a) of the Internal
Revenue Code (the Code).

Complete all entries in accordance with
the instructions to the Form 5500.

Official Use Only
OMB Nos. 1210 - 0110
1210 - 0089
2007

This Form is Open to
Public Inspection

Part I Annual Report Identification Information

For the calendar plan year 2007 or fiscal plan year beginning September 01, 2007, and ending August 31, 2008

- A** This return/report is for:
- (1) ☒ a multiemployer plan; (3) ☐ a multiple-employer plan;
(2) ☐ a single-employer plan (other than a multiple-employer plan); (4) ☐ a DFE (specify)
- B** This return/report is:
- (1) ☐ the first return/report filed for the plan; (3) ☐ the final return/report filed for the plan;
(2) ☐ the amended return/report; (4) ☐ a short plan year return/report (less than 12 months).
- C** If the plan is a collectively-bargained plan, check here ☐
- D** If you filed for an extension of time to file, check the box and attach a copy of the extension application ☐

Part II Basic Plan Information - enter all requested information.

- 1a** Name of plan
IBEW LOCAL 325 PENSION FUND
- 1b** Three-digit plan number (PN) 001
- 1c** Effective date of plan (mo., day, yr.)
June 01, 1963
- 2a** Plan sponsor's name and address (employer, if for a single-employer plan)
(Address should include room or suite no.)
TRUSTEES OF IBEW LOCAL 325 PENSION FUND
24 EMMA STREET
BINGHAMTON NY 13905-2502
- 2b** Employer Identification Number (EIN)
16-6098105
- 2c** Sponsor's telephone number
607-797-1919
- 2d** Business code (see instructions)
525100

Caution: A penalty for the late or incomplete filing of this return/report will be assessed unless reasonable cause is established.
Under penalties of perjury and other penalties set forth in the instructions, I declare that I have examined this return/report, including accompanying schedules, statements and attachments, and to the best of my knowledge and belief, it is true, correct, and complete.

JAMES COLLINS

Signature of plan administrator

Date

Typed or printed name of individual signing as plan administrator

TRUSTEES OF IBEW LOCAL 325

Signature of employer/plan sponsor/DFE

Date

Typed or printed name of individual signing as employer, plan sponsor or DFE as applicable

For Paperwork Reduction Act Notice and OMB Control Numbers, see the instructions for Form 5500.

v2.3

Form 5500 (2007)

- 3a** Plan administrator's name and address (if same as plan sponsor, enter "Same")
SAME
- 3b** Administrator's EIN
- 3c** Administrator's telephone number

- 4** If the name and/or EIN of the plan sponsor has changed since the last return/report filed for this plan, enter the name, EIN and the plan number from the last return/report below:
- a** Sponsor's name
- b** EIN
- c** PN

5 Preparer information (optional) **a** Name (including firm name, if applicable) and address

DARCANGELO & CO., LLP DARCANGELO & CO., LLP
200 EAST GARDEN STREET
ROME NY 13442-4300

b EIN

13-2550103

c Telephone no.

315-336-9220

6 Total number of participants at the beginning of the plan year

502

7 Number of participants as of the end of the plan year (welfare plans complete only lines **7a**, **7b**, **7c**, and **7d**)

a Active participants

257

b Retired or separated participants receiving benefits

171

c Other retired or separated participants entitled to future benefits

76

d Subtotal. Add lines **7a**, **7b**, and **7c**

504

e Deceased participants whose beneficiaries are receiving or are entitled to receive benefits

504

f Total. Add lines **7d** and **7e**

504

g Number of participants with account balances as of the end of the plan year (only defined contribution plans complete this item)

g

h Number of participants that terminated employment during the plan year with accrued benefits that were less than 100% vested

h

i If any participant(s) separated from service with a deferred vested benefit, enter the number of separated participants required to be reported on a Schedule SSA (Form 5500)

i

8 Benefits provided under the plan (complete 8a through 8c, as applicable)

a ☒ **Pension benefits** (check this box if the plan provides pension benefits and enter the applicable pension feature codes from the List of Plan Characteristics Codes (printed in the instructions)):

1B

b ☐ **Welfare benefits** (check this box if the plan provides welfare benefits and enter the applicable welfare feature codes from the List of Plan Characteristics Codes (printed in the instructions)):

9a Plan funding arrangement (check all that apply)

- (1) ☐ Insurance
(2) ☐ Section 412(i) insurance contracts
(3) ☐ Trust
(4) ☐ General assets of the sponsor

9b Plan benefit arrangement (check all that apply)

- (1) ☐ Insurance
(2) ☐ Section 412(i) insurance contracts
(3) ☐ Trust
(4) ☐ General assets of the sponsor

10 Schedules attached (Check all applicable boxes and, where indicated, enter the number attached. See instructions.)

a **Pension Benefit Schedules**

- (1) ☐ **R** (Retirement Plan Information)
(2) ☐ **OT** (Qualified Pension Plan Coverage Information)

If a Schedule T is not attached because the plan is relying on coverage testing information for a prior year, enter the year

- (3) ☒ **B** (Actuarial Information)
(4) ☐ **E** (ESOP Annual Information)
(5) ☐ **SSA** (Separated Vested participant Information)

b **Financial Schedules**

- (1) ☒ **H** (Financial Information)
(2) ☐ **I** (Financial Information – Small Plan)
(3) ☒ **1 A** (Insurance Information)
(4) ☒ **C** (Service Provider Information)
(5) ☒ **D** (DFE/Participating Plan Information)
(6) ☐ **G** (Financial Transaction Schedules)



Form 5500
Department of the Treasury
Internal Revenue Service
Department of Labor
Employee Benefits Security
Administration
Pension Benefit Guaranty Corporation

Annual Return/Report of Employee Benefit Plan

This form is required to be filed under sections 104 and 4065 of the Employee Retirement Income Security Act of 1974 (ERISA) and sections 6039D, 6047(e), 6057(b), and 6058(a) of the Internal Revenue Code (the Code).

Complete all entries in accordance with
the instructions to the Form 5500.

Official Use Only
OMB Nos. 1210 - 0110
1210 - 0089
2008
This Form is Open to
Public Inspection

Part I Annual Report Identification Information

For the calendar plan year 2008 or fiscal plan year beginning July 01, 2008, and ending June 30, 2009

- A** This return/report is for:
- (1) ☒ a multiemployer plan; (3) ☐ a multiple-employer plan;
(2) ☐ a single-employer plan (other than a multiple-employer plan); (4) ☐ a DFE (specify)
- B** This return/report is:
- (1) ☐ the first return/report filed for the plan; (3) ☐ the final return/report filed for the plan;
(2) ☐ the amended return/report; (4) ☐ a short plan year return/report (less than 12 months).
- C** If the plan is a collectively-bargained plan, check here ☒
- D** If you filed for an extension of time to file, check the box and attach a copy of the extension application ☐

Part II Basic Plan Information - enter all requested information.

- 1a** Name of plan
I.B.E.W. LOCAL 910 ANNUITY FUND
- 1b** Three-digit plan number (PN) 002
- 1c** Effective date of plan (mo., day, yr.)
April 01, 1988
- 2a** Plan sponsor's name and address (employer, if for a single-employer plan)
(Address should include room or suite no.)
I.B.E.W. LOCAL 910 ANNUITY FUND
25001 WATER STREET
WATERTOWN NY 13601-2145
- 2b** Employer Identification Number (EIN)
22-6447520
- 2c** Sponsor's telephone number
315-782-5941
- 2d** Business code (see instructions)
561110

Caution: A penalty for the late or incomplete filing of this return/report will be assessed unless reasonable cause is established. Under penalties of perjury and other penalties set forth in the instructions, I declare that I have examined this return/report, including accompanying schedules, statements and attachments, and to the best of my knowledge and belief, it is true, correct, and complete.

F

Signature of plan administrator

Date

Typed or printed name of individual signing as plan administrator

Signature of employer/plan sponsor/DFE

Date

Typed or printed name of individual signing as employer, plan sponsor or DFE as applicable

For Paperwork Reduction Act Notice and OMB Control Numbers, see the instructions for Form 5500.

v11.3

Form 5500 (2008)

- 3a** Plan administrator's name and address (if same as plan sponsor, enter "Same")

TRUSTEES OF PLAN
25001 WATER STREET
WATERTOWN NY 13601-2145

- 3b** Administrator's EIN

22-6447520

- 3c** Administrator's telephone number

315-782-5941

- 4** If the name and/or EIN of the plan sponsor has changed since the last return/report filed for this plan, enter the name, EIN and the plan number from the last return/report below:

b EIN

c PN

a Sponsor's name

5 Preparer information (optional) **a** Name (including firm name, if applicable) and address

STACKEL & NAVARRA, CPA, PC
216 WASHINGTON ST STE 402
WATERTOWN NY 13601-3336

b EIN

16-1215909

c Telephone no.

315-782-1220

6 Total number of participants at the beginning of the plan year

625

7 Number of participants as of the end of the plan year (welfare plans complete only lines **7a**, **7b**, **7c**, and **7d**)

a Active participants

648

b Retired or separated participants receiving benefits

c Other retired or separated participants entitled to future benefits

d Subtotal. Add lines **7a**, **7b**, and **7c**

648

e Deceased participants whose beneficiaries are receiving or are entitled to receive benefits

f Total. Add lines **7d** and **7e**

648

g Number of participants with account balances as of the end of the plan year (only defined contribution plans complete this item)

648

h Number of participants that terminated employment during the plan year with accrued benefits that were less than 100% vested

i If any participant(s) separated from service with a deferred vested benefit, enter the number of separated participants required to be reported on a Schedule SSA (Form 5500)

8 Benefits provided under the plan (complete **8a** through **8c**, as applicable)

a ☒ **Pension benefits** (check this box if the plan provides pension benefits and enter the applicable pension feature codes from the List of Plan Characteristics Codes (printed in the instructions)):

2E

b ☐ **Welfare benefits** (check this box if the plan provides welfare benefits and enter the applicable welfare feature codes from the List of Plan Characteristics Codes (printed in the instructions)):

9a Plan funding arrangement (check all that apply)

(1) ☐ Insurance

(2) ☐ Section 412(e)(3) insurance contracts

(3) ☐ Trust

(4) ☐ General assets of the sponsor

9b Plan benefit arrangement (check all that apply)

(1) ☐ Insurance

(2) ☐ Section 412(e)(3) insurance contracts

(3) ☐ Trust

(4) ☐ General assets of the sponsor

10 Schedules attached (Check all applicable boxes and, where indicated, enter the number attached. See instructions.)

a **Pension Benefit Schedules**

(1) ☐ **R** (Retirement Plan Information)

(2) ☐ **OT** (Qualified Pension Plan Coverage Information)

If a Schedule T is not attached because the plan is relying on coverage testing information for a prior year, enter the year

(3) ☐ **B** (Actuarial Information)

(4) ☐ **E** (ESOP Annual Information)

(5) ☐ **SSA** (Separated Vested participant Information)

b **Financial Schedules**

(1) ☒ **H** (Financial Information)

(2) ☐ **I** (Financial Information – Small Plan)

(3) ☐ **A** (Insurance Information)

(4) ☒ **C** (Service Provider Information)

(5) ☒ **D** (DFE/Participating Plan Information)

(6) ☐ **G** (Financial Transaction Schedules)



Form 5500
Department of the Treasury
Internal Revenue Service
Department of Labor
Employee Benefits Security
Administration
Pension Benefit Guaranty Corporation

Annual Return/Report of Employee Benefit Plan

This form is required to be filed under sections 104 and 4065 of the
Employee Retirement Income Security Act of 1974 (ERISA) and
sections 6039D, 6047(e), 6057(b), and 6058(a) of the Internal
Revenue Code (the Code).

Complete all entries in accordance with
the instructions to the Form 5500.

Official Use Only
OMB Nos. 1210 - 0110
1210 - 0089
2008
This Form is Open to
Public Inspection

Part I Annual Report Identification Information

For the calendar plan year 2008 or fiscal plan year beginning July 01, 2008, and ending June 30, 2009

- A** This return/report is for:
- (1) ☒ a multiemployer plan; (3) ☐ a multiple-employer plan;
(2) ☐ a single-employer plan (other than a multiple-employer plan); (4) ☐ a DFE (specify)
- B** This return/report is:
- (1) ☐ the first return/report filed for the plan; (3) ☐ the final return/report filed for the plan;
(2) ☐ the amended return/report; (4) ☐ a short plan year return/report (less than 12 months).
- C** If the plan is a collectively-bargained plan, check here ☒
- D** If you filed for an extension of time to file, check the box and attach a copy of the extension application ☐

Part II Basic Plan Information - enter all requested information.

1a Name of plan

I.B.E.W. LOCAL 910 PENSION FUND

1b Three-digit plan number (PN) 001

1c Effective date of plan (mo., day, yr.)
July 01, 1966

2a Plan sponsor's name and address (employer, if for a single-employer plan) (Address should include room or suite no.)

I.B.E.W. LOCAL 910 PENSION FUND
25001 WATER STREET
WATERTOWN NY 13601-2145

2b Employer Identification Number (EIN)
16-6149240

2c Sponsor's telephone number
315-782-5941

2d Business code (see instructions)
561110

Caution: A penalty for the late or incomplete filing of this return/report will be assessed unless reasonable cause is established. Under penalties of perjury and other penalties set forth in the instructions, I declare that I have examined this return/report, including accompanying schedules, statements and attachments, and to the best of my knowledge and belief, it is true, correct, and complete.

Signature of plan administrator

Date

Typed or printed name of individual signing as plan administrator

Signature of employer/plan sponsor/DFE

Date

Typed or printed name of individual signing as employer, plan sponsor or DFE as applicable

For Paperwork Reduction Act Notice and OMB Control Numbers, see the instructions for Form 5500.
v11.3

Form 5500 (2008)

3a Plan administrator's name and address (if same as plan sponsor, enter "Same")

TRUSTEES OF THE PLAN FOR I.B.E.W. LOCAL 910
25001 WATER STREET
WATERTOWN NY 13601-2145

3b Administrator's EIN
16-6100240

3c Administrator's telephone number
315-782-5941

4 If the name and/or EIN of the plan sponsor has changed since the last return/report filed for this plan, enter the name, EIN and the plan number from the last return/report below:

b EIN

c PN

a Sponsor's name

5 Preparer information (optional)		a Name (including firm name, if applicable) and address	b EIN	c Telephone no.
6 Total number of participants at the beginning of the plan year			6	661
7 Number of participants as of the end of the plan year (welfare plans complete only lines 7a , 7b , 7c , and 7d)				
a Active participants			a	387
b Retired or separated participants receiving benefits			b	182
c Other retired or separated participants entitled to future benefits			c	79
d Subtotal. Add lines 7a , 7b , and 7c			d	648
e Deceased participants whose beneficiaries are receiving or are entitled to receive benefits			e	
f Total. Add lines 7d and 7e			f	648
g Number of participants with account balances as of the end of the plan year (only defined contribution plans complete this item)			g	
h Number of participants that terminated employment during the plan year with accrued benefits that were less than 100% vested			h	
i If any participant(s) separated from service with a deferred vested benefit, enter the number of separated participants required to be reported on a Schedule SSA (Form 5500)			i	4
8 Benefits provided under the plan (complete 8a through 8c, as applicable)				
a <input checked="" type="checkbox"/> Pension benefits (check this box if the plan provides pension benefits and enter the applicable pension feature codes from the List of Plan Characteristics Codes (printed in the instructions)):				
1G - - - - -				
b <input type="checkbox"/> Welfare benefits (check this box if the plan provides welfare benefits and enter the applicable welfare feature codes from the List of Plan Characteristics Codes (printed in the instructions)):				
- - - - -				
9a Plan funding arrangement (check all that apply)		9b Plan benefit arrangement (check all that apply)		
(1) <input type="checkbox"/> Insurance		(1) <input type="checkbox"/> Insurance		
(2) <input type="checkbox"/> Section 412(e)(3) insurance contracts		(2) <input type="checkbox"/> Section 412(e)(3) insurance contracts		
(3) <input type="checkbox"/> Trust		(3) <input type="checkbox"/> Trust		
(4) <input type="checkbox"/> General assets of the sponsor		(4) <input type="checkbox"/> General assets of the sponsor		
10 Schedules attached (Check all applicable boxes and, where indicated, enter the number attached. See instructions.)				
a Pension Benefit Schedules		b Financial Schedules		
(1) <input checked="" type="checkbox"/> R (Retirement Plan Information)		(1) <input checked="" type="checkbox"/> H (Financial Information)		
(2) <input type="checkbox"/> T (Qualified Pension Plan Coverage Information)		(2) <input type="checkbox"/> I (Financial Information – Small Plan)		
		(3) <input type="checkbox"/> A (Insurance Information)		
		(4) <input checked="" type="checkbox"/> C (Service Provider Information)		
		(5) <input checked="" type="checkbox"/> D (DFE/Participating Plan Information)		
		(6) <input type="checkbox"/> G (Financial Transaction Schedules)		
If a Schedule T is not attached because the plan is relying on coverage testing information for a prior year, enter the year				
(3) <input checked="" type="checkbox"/> B (Actuarial Information)				
(4) <input type="checkbox"/> E (ESOP Annual Information)				
(5) <input checked="" type="checkbox"/> SSA (Separated Vested participant Information)				



Form 5500
Department of the Treasury
Internal Revenue Service
Department of Labor
Employee Benefits Security
Administration
Pension Benefit Guaranty Corporation

Annual Return/Report of Employee Benefit Plan

This form is required to be filed under sections 104 and 4065 of the
Employee Retirement Income Security Act of 1974 (ERISA) and
sections 6039D, 6047(e), 6057(b), and 6058(a) of the Internal
Revenue Code (the Code).

Complete all entries in accordance with
the instructions to the Form 5500.

Official Use Only
OMB Nos. 1210 - 0110
1210 - 0089
2008

This Form is Open to
Public Inspection

Part I Annual Report Identification Information

For the calendar plan year 2008 or fiscal plan year beginning July 01, 2008, and ending December 31, 2008

- A** This return/report is for:
- (1) ☒ a multiemployer plan;
- (2) ☐ a single-employer plan (other than a multiple-employer plan);
- (3) ☐ a multiple-employer plan;
- (4) ☐ a DFE (specify)
- B** This return/report is:
- (1) ☐ the first return/report filed for the plan;
- (2) ☐ the amended return/report;
- (3) ☐ the final return/report filed for the plan;
- (4) ☐ a short plan year return/report (less than 12 months).
- C** If the plan is a collectively-bargained plan, check here ☒
- D** If you filed for an extension of time to file, check the box and attach a copy of the extension application ☒

Part II Basic Plan Information - enter all requested information.

1a Name of plan

IBEW LOCAL 1249 PENSION PLAN

1b Three-digit
plan number (PN) 001

1c Effective date of plan (mo., day, yr.)
July 03, 1962

2a Plan sponsor's name and address (employer, if for a single-employer plan) (Address should include room or suite no.)

IBEW LOCAL 1249 PENSION PLAN BOARD OF TRUSTEES
6518 FREMONT ROAD, P.O. BOX 301
EAST SYRACUSE NY 13057-9453

2b Employer Identification Number (EIN)
15-6035161

2c Sponsor's telephone number
315-656-8390

2d Business code (see instructions)
238210

Caution: A penalty for the late or incomplete filing of this return/report will be assessed unless reasonable cause is established.
Under penalties of perjury and other penalties set forth in the instructions, I declare that I have examined this return/report, including accompanying schedules, statements and attachments, and to the best of my knowledge and belief, it is true, correct, and complete.

DANIEL DAFOE

Signature of plan administrator

Date

Typed or printed name of individual signing as plan administrator

11/14/1449

IBEW LOCAL 1249 PENSION PLAN

Signature of employer/plan sponsor/DFE

Date

Typed or printed name of individual signing as employer, plan
sponsor or DFE as applicable

For Paperwork Reduction Act Notice and OMB Control Numbers, see the instructions for Form 5500.

v11.3

Form 5500 (2008)

3a Plan administrator's name and address (if same as plan sponsor, enter "Same")

SA14F.

3b Administrator's EIN

3c Administrator's telephone number

4 If the name and/or EIN of the plan sponsor has changed since the last return/report filed for this plan, enter the name, EIN and the plan number from the last return/report below:

b EIN

c PN

a Sponsor's name

5 Preparer information (optional) a Name (including firm name, if applicable) and address

BRARN MILLKK COIDPANY LLP
115 SOT-AR SRK(EET 100
SIXACUSE W 13204

b EIN

23-3060766

c Telephone no.

154712777

6 Total number of participants at the beginning of the plan year

2125

7 Number of participants as of the end of the plan year (welfare plans complete only lines 7a, 7b, 7c, and 7d)

a Active participants

1284

b Retired or separated participants receiving benefits

384

c Other retired or separated participants entitled to future benefits

506

d Subtotal. Add lines 7a, 7b, and 7c

2174

e Deceased participants whose beneficiaries are receiving or are entitled to receive benefits

123

f Total. Add lines 7d and 7e

2297

g Number of participants with account balances as of the end of the plan year (only defined contribution plans complete this item)

g

h Number of participants that terminated employment during the plan year with accrued benefits that were less than 100% vested

h

i If any participant(s) separated from service with a deferred vested benefit, enter the number of separated participants required to be reported on a Schedule SSA (Form 5500)

43

8 Benefits provided under the plan (complete 8a through 8c, as applicable)

a ☒ Pension benefits (check this box if the plan provides pension benefits and enter the applicable pension feature codes from the List of Plan Characteristics Codes (printed in the instructions)):

1A 1B - - - - -

b ☐ Welfare benefits (check this box if the plan provides welfare benefits and enter the applicable welfare feature codes from the List of Plan Characteristics Codes (printed in the instructions)):

- - - - -

9a Plan funding arrangement (check all that apply)

- (1) ☐ Insurance
(2) ☐ Section 412(e)(3) insurance contracts
(3) ☐ Trust
(4) ☐ General assets of the sponsor

9b Plan benefit arrangement (check all that apply)

- (1) ☐ Insurance
(2) ☐ Section 412(e)(3) insurance contracts
(3) ☐ Trust
(4) ☐ General assets of the sponsor

10 Schedules attached (Check all applicable boxes and, where indicated, enter the number attached. See instructions.)

a Pension Benefit Schedules

- (1) ☒ R (Retirement Plan Information)
(2) ☐ OT (Qualified Pension Plan Coverage Information)

If a Schedule T is not attached because the plan is relying on coverage testing information for a prior year, enter the year

- (3) ☒ B (Actuarial Information)
(4) ☐ E (ESOP Annual Information)
(5) ☒ SSA (Separated Vested participant Information)

b Financial Schedules

- (1) ☒ H (Financial Information)
(2) ☐ I (Financial Information - Small Plan)
(3) ☒ 1 A (Insurance Information)
(4) ☒ C (Service Provider Information)
(5) ☒ D (DFE/Participating Plan Information)
(6) ☐ G (Financial Transaction Schedules)



Form 5500
Department of the Treasury
Internal Revenue Service
Department of Labor
Employee Benefits Security
Administration
Pension Benefit Guaranty Corporation

Annual Return/Report of Employee Benefit Plan

This form is required to be filed under sections 104 and 4065 of the Employee Retirement Income Security Act of 1974 (ERISA) and sections 6039D, 6047(e), 6057(b), and 6058(a) of the Internal Revenue Code (the Code).

Complete all entries in accordance with the instructions to the Form 5500.

Official Use Only
OMB Nos. 1210 - 0110
1210 - 0089
2008
This Form is Open to
Public Inspection

Part I Annual Report Identification Information

For the calendar plan year 2008 or fiscal plan year beginning January 01, 2008, and ending December 31, 2008

- A** This return/report is for:
- (1) ☒ a multiemployer plan; (3) ☐ a multiple-employer plan;
(2) ☐ a single-employer plan (other than a multiple-employer plan); (4) ☐ a DFE (specify)
- B** This return/report is:
- (1) ☐ the first return/report filed for the plan; (3) ☐ the final return/report filed for the plan;
(2) ☐ the amended return/report; (4) ☐ a short plan year return/report (less than 12 months).
- C** If the plan is a collectively-bargained plan, check here ☒
- D** If you filed for an extension of time to file, check the box and attach a copy of the extension application ☒

Part II Basic Plan Information - enter all requested information.

- 1a** Name of plan
LABORERS LOCAL 103 ANNUITY FUND
- 1b** Three-digit plan number (PN) 002
- 1c** Effective date of plan (mo., day, yr.)
June 01, 2002
- 2a** Plan sponsor's name and address (employer, if for a single-employer plan)
(Address should include room or suite no.)
TRUSTEES OF LABORERS LOCAL 103 ANNUITY FUND
P.O. BOX 571
GENEVA NY 14456-0571
- 2b** Employer Identification Number (EIN)
01-6214544
- 2c** Sponsor's telephone number
315-539-4220
- 2d** Business code (see instructions)
525100

Caution: A penalty for the late or incomplete filing of this return/report will be assessed unless reasonable cause is established. Under penalties of perjury and other penalties set forth in the instructions, I declare that I have examined this return/report, including accompanying schedules, statements and attachments, and to the best of my knowledge and belief, it is true, correct, and complete.

UNION TRUSTEE

Signature of plan administrator

Date

Typed or printed name of individual signing as plan administrator

MANAGEMENT TRUSTEE

Signature of employer/plan sponsor/DFE

Date

Typed or printed name of individual signing as employer, plan sponsor or DFE as applicable

For Paperwork Reduction Act Notice and OMB Control Numbers, see the instructions for Form 5500.

v11.3

Form 5500 (2008)

3a Plan administrator's name and address (if same as plan sponsor, enter "Same")

3b Administrator's EIN

3c Administrator's telephone number

SAIME

4 If the name and/or EIN of the plan sponsor has changed since the last return/report filed for this plan, enter the name, EIN and the plan number from the last return/report below:

b EIN

c PN

a Sponsor's name

5 Preparer information (optional)		a Name (including firm name, if applicable) and address	b EIN	c Telephone no.
6 Total number of participants at the beginning of the plan year			6	166
7 Number of participants as of the end of the plan year (welfare plans complete only lines 7a , 7b , 7c , and 7d)				
a Active participants			a	159
b Retired or separated participants receiving benefits			b	
c Other retired or separated participants entitled to future benefits			c	
d Subtotal. Add lines 7a , 7b , and 7c			d	159
e Deceased participants whose beneficiaries are receiving or are entitled to receive benefits			e	
f Total. Add lines 7d and 7e			f	159
g Number of participants with account balances as of the end of the plan year (only defined contribution plans complete this item)			g	159
h Number of participants that terminated employment during the plan year with accrued benefits that were less than 100% vested			h	
i If any participant(s) separated from service with a deferred vested benefit, enter the number of separated participants required to be reported on a Schedule SSA (Form 5500)			i	
8 Benefits provided under the plan (complete 8a through 8c, as applicable)				
a <input checked="" type="checkbox"/> Pension benefits (check this box if the plan provides pension benefits and enter the applicable pension feature codes from the List of Plan Characteristics Codes (printed in the instructions)):				
2E - - - - -				
b <input type="checkbox"/> Welfare benefits (check this box if the plan provides welfare benefits and enter the applicable welfare feature codes from the List of Plan Characteristics Codes (printed in the instructions)):				
- - - - -				
9a Plan funding arrangement (check all that apply)		9b Plan benefit arrangement (check all that apply)		
(1) <input type="checkbox"/> Insurance		(1) <input type="checkbox"/> Insurance		
(2) <input type="checkbox"/> Section 412(e)(3) insurance contracts		(2) <input type="checkbox"/> Section 412(e)(3) insurance contracts		
(3) <input type="checkbox"/> Trust		(3) <input type="checkbox"/> Trust		
(4) <input type="checkbox"/> General assets of the sponsor		(4) <input type="checkbox"/> General assets of the sponsor		
10 Schedules attached (Check all applicable boxes and, where indicated, enter the number attached. See instructions.)				
a Pension Benefit Schedules		b Financial Schedules		
(1) <input type="checkbox"/> R (Retirement Plan Information)		(1) <input checked="" type="checkbox"/> H (Financial Information)		
(2) <input type="checkbox"/> OT (Qualified Pension Plan Coverage Information)		(2) <input type="checkbox"/> I (Financial Information – Small Plan)		
		(3) <input type="checkbox"/> A (Insurance Information)		
		(4) <input checked="" type="checkbox"/> C (Service Provider Information)		
		(5) <input checked="" type="checkbox"/> D (DFE/Participating Plan Information)		
		(6) <input type="checkbox"/> G (Financial Transaction Schedules)		
If a Schedule T is not attached because the plan is relying on coverage testing information for a prior year, enter the year				
(3) <input type="checkbox"/> B (Actuarial Information)				
(4) <input type="checkbox"/> E (ESOP Annual Information)				
(5) <input type="checkbox"/> SSA (Separated Vested participant Information)				



Form 5500
Department of the Treasury
Internal Revenue Service
Department of Labor
Employee Benefits Security
Administration
Pension Benefit Guaranty Corporation

Annual Return/Report of Employee Benefit Plan

This form is required to be filed under sections 104 and 4065 of the Employee Retirement Income Security Act of 1974 (ERISA) and sections 6039D, 6047(e), 6057(b), and 6058(a) of the Internal Revenue Code (the Code).

Complete all entries in accordance with
the instructions to the Form 5500.

Official Use Only
OMB Nos. 1210 - 0110
1210 - 0089
2008
This Form is Open to
Public Inspection

Part I Annual Report Identification Information

For the calendar plan year 2008 or fiscal plan year beginning January 01, 2008, and ending December 31, 2008

- A This return/report is for:
- (1) ☒ a multiemployer plan;
- (2) ☐ a single-employer plan (other than a multiple-employer plan);
- (3) ☐ a multiple-employer plan;
- (4) ☐ a DFE (specify)
- B This return/report is:
- (1) ☐ the first return/report filed for the plan;
- (2) ☐ the amended return/report;
- (3) ☐ the final return/report filed for the plan;
- (4) ☐ a short plan year return/report (less than 12 months).
- C If the plan is a collectively-bargained plan, check here ☒
- D If you filed for an extension of time to file, check the box and attach a copy of the extension application ☒

Part II Basic Plan Information - enter all requested information.

1a Name of plan

LABORERS LOCAL 103 PENSION PLAN

1b Three-digit
plan number (PN) 001

1c Effective date of plan (mo., day, yr.)
May 01, 1964

2a Plan sponsor's name and address (employer, if for a single-employer plan) (Address should include room or suite no.)

TRUSTEES OF LABORERS LOCAL 103 PENSION FUND
P.O. BOX 571
GENEVA NY 14456-0571

2b Employer Identification Number (EIN)
16-6062260

2c Sponsor's telephone number
315-539-4220

2d Business code (see instructions)
525100

Caution: A penalty for the late or incomplete filing of this return/report will be assessed unless reasonable cause is established. Under penalties of perjury and other penalties set forth in the instructions, I declare that I have examined this return/report, including accompanying schedules, statements and attachments, and to the best of my knowledge and belief, it is true, correct, and complete.

UNION TRUSTEE

Signature of plan administrator

Date

Typed or printed name of individual signing as plan administrator

MANAGEMENT TRUSTEE

Signature of employer/plan sponsor/DFE

Date

Typed or printed name of individual signing as employer, plan sponsor or DFE as applicable

For Paperwork Reduction Act Notice and OMB Control Numbers, see the instructions for Form 5500.

v11.3

Form 5500 (2008)

3a Plan administrator's name and address (if same as plan sponsor, enter "Same")

SAME

3b Administrator's EIN

3c Administrator's telephone number

4 If the name and/or EIN of the plan sponsor has changed since the last return/report filed for this plan, enter the name, EIN and the plan number from the last return/report below:

b EIN

c PN

a Sponsor's name

5 Preparer information (optional) a Name (including firm name, if applicable) and address

b EIN

c Telephone no.

6 Total number of participants at the beginning of the plan year

6 268

7 Number of participants as of the end of the plan year (welfare plans complete only lines 7a, 7b, 7c, and 7d)

a Active participants

a 99

b Retired or separated participants receiving benefits

b 103

c Other retired or separated participants entitled to future benefits

c 39

d Subtotal. Add lines 7a, 7b, and 7c

d 241

e Deceased participants whose beneficiaries are receiving or are entitled to receive benefits

e 20

f Total. Add lines 7d and 7e

f 261

g Number of participants with account balances as of the end of the plan year (only defined contribution plans complete this item)

g

h Number of participants that terminated employment during the plan year with accrued benefits that were less than 100% vested

h

i If any participant(s) separated from service with a deferred vested benefit, enter the number of separated participants required to be reported on a Schedule SSA (Form 5500)

i 2

8 Benefits provided under the plan (complete 8a through 8c, as applicable)

a ☒ Pension benefits (check this box if the plan provides pension benefits and enter the applicable pension feature codes from the List of Plan Characteristics Codes (printed in the instructions)):

1B 1G - - - - -

b ☐ Welfare benefits (check this box if the plan provides welfare benefits and enter the applicable welfare feature codes from the List of Plan Characteristics Codes (printed in the instructions)):

- - - - -

9a Plan funding arrangement (check all that apply)

(1) ☐ Insurance

(2) ☐ Section 412(e)(3) insurance contracts

(3) ☐ Trust

(4) ☐ General assets of the sponsor

9b Plan benefit arrangement (check all that apply)

(1) ☐ Insurance

(2) ☐ Section 412(e)(3) insurance contracts

(3) ☐ Trust

(4) ☐ General assets of the sponsor

10 Schedules attached (Check all applicable boxes and, where indicated, enter the number attached. See instructions.)

a Pension Benefit Schedules

(1) ☒ R (Retirement Plan Information)

(2) ☐ T (Qualified Pension Plan Coverage Information)

If a Schedule T is not attached because the plan is relying on coverage testing information for a prior year, enter the year

(3) ☐ B (Actuarial Information)

(4) ☐ E (ESOP Annual Information)

(5) ☐ SSA (Separated Vested participant Information)

b Financial Schedules

(1) ☒ H (Financial Information)

(2) ☐ I (Financial Information - Small Plan)

(3) ☐ A (Insurance Information)

(4) ☒ C (Service Provider Information)

(5) ☒ D (DFE/Participating Plan Information)

(6) ☐ G (Financial Transaction Schedules)



Form 5500
Department of the Treasury
Internal Revenue Service
Department of Labor
Employee Benefits Security
Administration
Pension Benefit Guaranty Corporation

Annual Return/Report of Employee Benefit Plan

This form is required to be filed under sections 104 and 4065 of the
Employee Retirement Income Security Act of 1974 (ERISA) and
sections 6039D, 6047(e), 6057(b), and 6058(a) of the Internal
Revenue Code (the Code).

Complete all entries in accordance with
the instructions to the Form 5500.

Official Use Only
OMB Nos. 1210 - 0110
1210 - 0089
2008

**This Form is Open to
Public Inspection**

Part I Annual Report Identification Information

For the calendar plan year 2008 or fiscal plan year beginning October 01, 2008, and ending September 30, 2009

- A** This return/report is for:
- (1) ☒ a multiemployer plan; (3) ☐ a multiple-employer plan;
(2) ☐ a single-employer plan (other than a multiple-employer plan); (4) ☐ a DFE (specify)
- B** This return/report is:
- (1) ☐ the first return/report filed for the plan; (3) ☐ the final return/report filed for the plan;
(2) ☐ the amended return/report; (4) ☐ a short plan year return/report (less than 12 months).
- C** If the plan is a collectively-bargained plan, check here ☒
- D** If you filed for an extension of time to file, check the box and attach a copy of the extension application ☒

Part II Basic Plan Information - enter all requested information.

- 1a** Name of plan
LOCAL 73 ANNUITY FUND
- 1b** Three-digit plan number (PN) 002
- 1c** Effective date of plan (mo., day, yr.)
- 2a** Plan sponsor's name and address (employer, if for a single-employer plan)
(Address should include room or suite no.)
BOARD OF TRUSTEES OF LOCAL 73 ANNUITY FUND
P.O. BOX 911
OSWLEGO NY 13126-0911
- 2b** Employer Identification Number (EIN)
16-1586694
- 2c** Sponsor's telephone number
315-343-1808
- 2d** Business code (see instructions)
238900

Caution: A penalty for the late or incomplete filing of this return/report will be assessed unless reasonable cause is established.
Under penalties of perjury and other penalties set forth in the instructions, I declare that I have examined this return/report, including accompanying schedules, statements and attachments, and to the best of my knowledge and belief, it is true, correct, and complete.

JAMES P. GAFF'N);Y

Signature of plan administrator

Date

Typed or printed name of individual signing as plan administrator

PATKICK RARROLL

Signature of employer/plan sponsor/DFE

Date

Typed or printed name of individual signing as employer, plan sponsor or DFE as applicable

For Paperwork Reduction Act Notice and OMB Control Numbers, see the instructions for Form 5500.
v11.3

Form 5500 (2008)

3a Plan administrator's name and address (if same as plan sponsor, enter "Same")

3b Administrator's EIN

JAMMS P. GAFF14BY
705 RAGT SENECA STREET
OSWISGO NY 13126

22-3739111

3c Administrator's telephone number
315-343-1808

4 If the name and/or EIN of the plan sponsor has changed since the last return/report filed for this plan, enter the name, EIN and the plan number from the last return/report below:

b EIN

a Sponsor's name

c PN

5 Preparer information (optional) **a** Name (including firm name, if applicable) and address

PARENTEBRARD LLC THOMAS E. RILEY
115 SOLAR SFREET 100
SYKACUSE 13204

b EIN

23-2932984

c Telephone no.

315-471-2777

6 Total number of participants at the beginning of the plan year

560

7 Number of participants as of the end of the plan year (welfare plans complete only lines **7a**, **7b**, **7c**, and **7d**)

a Active participants

a 406

b Retired or separated participants receiving benefits

b 29

c Other retired or separated participants entitled to future benefits

c 150

d Subtotal. Add lines **7a**, **7b**, and **7c**

d 585

e Deceased participants whose beneficiaries are receiving or are entitled to receive benefits

e

f Total. Add lines **7d** and **7e**

f 585

g Number of participants with account balances as of the end of the plan year (only defined contribution plans complete this item)

g 585

h Number of participants that terminated employment during the plan year with accrued benefits that were less than 100% vested

h

i If any participant(s) separated from service with a deferred vested benefit, enter the number of separated participants required to be reported on a Schedule SSA (Form 5500)

i 11

8 Benefits provided under the plan (complete **8a** through **8c**, as applicable)

a ☒ **Pension benefits** (check this box if the plan provides pension benefits and enter the applicable pension feature codes from the List of Plan Characteristics Codes (printed in the instructions)):

2E

b ☐ **Welfare benefits** (check this box if the plan provides welfare benefits and enter the applicable welfare feature codes from the List of Plan Characteristics Codes (printed in the instructions)):

9a Plan funding arrangement (check all that apply)

- (1) ☐ Insurance
(2) ☐ Section 412(e)(3) insurance contracts
(3) ☐ Trust
(4) ☐ General assets of the sponsor

9b Plan benefit arrangement (check all that apply)

- (1) ☐ Insurance
(2) ☐ Section 412(e)(3) insurance contracts
(3) ☐ Trust
(4) ☐ General assets of the sponsor

10 Schedules attached (Check all applicable boxes and, where indicated, enter the number attached. See instructions.)

a **Pension Benefit Schedules**

- (1) ☐ **R** (Retirement Plan Information)
(2) ☐ **OT** (Qualified Pension Plan Coverage Information)

If a Schedule T is not attached because the plan is relying on coverage testing information for a prior year, enter the year

- (3) ☐ **B** (Actuarial Information)
(4) ☐ **E** (ESOP Annual Information)
(5) ☐ **SSA** (Separated Vested participant Information)

b **Financial Schedules**

- (1) ☒ **H** (Financial Information)
(2) ☐ **I** (Financial Information – Small Plan)
(3) ☐ **0 A** (Insurance Information)
(4) ☒ **C** (Service Provider Information)
(5) ☒ **D** (DFE/Participating Plan Information)
(6) ☐ **G** (Financial Transaction Schedules)



Form 5500
Department of the Treasury
Internal Revenue Service
Department of Labor
Employee Benefits Security
Administration
Pension Benefit Guaranty Corporation

Annual Return/Report of Employee Benefit Plan

This form is required to be filed under sections 104 and 4065 of the
Employee Retirement Income Security Act of 1974 (ERISA) and
sections 6039D, 6047(e), 6057(b), and 6058(a) of the Internal
Revenue Code (the Code).

Complete all entries in accordance with
the instructions to the Form 5500.

Official Use Only
OMB Nos. 1210 - 0110
1210 - 0089
2008

**This Form is Open to
Public Inspection**

Part I Annual Report Identification Information

For the calendar plan year 2008 or fiscal plan year beginning July 01, 2008, and ending June 30, 2009

- A** This return/report is for:
- (1) ☒ a multiemployer plan; (3) ☐ a multiple-employer plan;
(2) ☐ a single-employer plan (other than a multiple-employer plan); (4) ☐ a DFE (specify)
- B** This return/report is:
- (1) ☐ the first return/report filed for the plan; (3) ☐ the final return/report filed for the plan;
(2) ☐ the amended return/report; (4) ☐ a short plan year return/report (less than 12 months).
- C** If the plan is a collectively-bargained plan, check here ☒
- D** If you filed for an extension of time to file, check the box and attach a copy of the extension application ☒

Part II Basic Plan Information - enter all requested information.

- 1a** Name of plan
LOCAL 73 RETIREMENT FUND
- 1b** Three-digit plan number (PN) 001
- 1c** Effective date of plan (mo., day, yr.)
July 01, 1419
- 2a** Plan sponsor's name and address (employer, if for a single-employer plan)
(Address should include room or suite no.)
LOCAL 73 RETIREMENT FUND
705 RAST SENECA STMEET, PO BOX 911
OSWJ5GO NY 13126-0911
- 2b** Employer Identification Number (EIN)
15-6016577
- 2c** Sponsor's telephone number
315-343-1808
- 2d** Business code (see instructions)
525100

Caution: A penalty for the late or incomplete filing of this return/report will be assessed unless reasonable cause is established.
Under penalties of perjury and other penalties set forth in the instructions, I declare that I have examined this return/report, including accompanying schedules, statements and attachments, and to the best of my knowledge and belief, it is true, correct, and complete.

JAIKAS GAFFNEY

Signature of plan administrator

Date

Typed or printed name of individual signing as plan administrator

LORAT. 73 RETIR1914KNT FUNI)

Signature of employer/plan sponsor/DFE

Date

Typed or printed name of individual signing as employer, plan sponsor or DFE as applicable

For Paperwork Reduction Act Notice and OMB Control Numbers, see the instructions for Form 5500.

Form 5500 (2008)

v11.3

3a Plan administrator's name and address (if same as plan sponsor, enter "Same")

3b Administrator's EIN

22-3739111

3c Administrator's telephone number

315-343-1808

JAMES GAFKNEY
705 EAST SENECA STREET PO BOX 911
OSWZGO NY 13126-0911

4 If the name and/or EIN of the plan sponsor has changed since the last return/report filed for this plan, enter the name, EIN and the plan number from the last return/report below:

b EIN

c PN

a Sponsor's name

5 Preparer information (optional) a Name (including firm name, if applicable) and address

PARENTEBEARN LLC THOMAS E. RILEY
115 SOLAR STREET 100
SYRACUSE 13204

b EIN

23-2932984

c Telephone no.

315-471-2777

6 Total number of participants at the beginning of the plan year

860

7 Number of participants as of the end of the plan year (welfare plans complete only lines 7a, 7b, 7c, and 7d)

a Active participants

a 339

b Retired or separated participants receiving benefits

b 363

c Other retired or separated participants entitled to future benefits

c 83

d Subtotal. Add lines 7a, 7b, and 7c

d 785

e Deceased participants whose beneficiaries are receiving or are entitled to receive benefits

e 83

f Total. Add lines 7d and 7e

f 868

g Number of participants with account balances as of the end of the plan year (only defined contribution plans complete this item)

g

h Number of participants that terminated employment during the plan year with accrued benefits that were less than 100% vested

h 1

i If any participant(s) separated from service with a deferred vested benefit, enter the number of separated participants required to be reported on a Schedule SSA (Form 5500)

i 1

8 Benefits provided under the plan (complete 8a through 8c, as applicable)

a ☒ Pension benefits (check this box if the plan provides pension benefits and enter the applicable pension feature codes from the List of Plan Characteristics Codes (printed in the instructions)):

1B - - - - -

b ☐ Welfare benefits (check this box if the plan provides welfare benefits and enter the applicable welfare feature codes from the List of Plan Characteristics Codes (printed in the instructions)):

- - - - -

9a Plan funding arrangement (check all that apply)

(1) ☐ Insurance

(2) ☐ Section 412(e)(3) insurance contracts

(3) ☐ Trust

(4) ☐ General assets of the sponsor

9b Plan benefit arrangement (check all that apply)

(1) ☐ Insurance

(2) ☐ Section 412(e)(3) insurance contracts

(3) ☐ Trust

(4) ☐ General assets of the sponsor

10 Schedules attached (Check all applicable boxes and, where indicated, enter the number attached. See instructions.)

a Pension Benefit Schedules

(1) ☒ R (Retirement Plan Information)

(2) ☐ OT (Qualified Pension Plan Coverage Information)

If a Schedule T is not attached because the plan is relying on coverage testing information for a prior year, enter the year

(3) ☒ B (Actuarial Information)

(4) ☐ E (ESOP Annual Information)

(5) ☒ SSA (Separated Vested participant Information)

b Financial Schedules

(1) ☒ H (Financial Information)

(2) ☐ I (Financial Information - Small Plan)

(3) ☒ 1 A (Insurance Information)

(4) ☒ C (Service Provider Information)

(5) ☒ D (DFE/Participating Plan Information)

(6) ☐ G (Financial Transaction Schedules)



Form 5500
Department of the Treasury
Internal Revenue Service
Department of Labor
Employee Benefits Security
Administration
Pension Benefit Guaranty Corporation

Annual Return/Report of Employee Benefit Plan

This form is required to be filed under sections 104 and 4065 of the
Employee Retirement Income Security Act of 1974 (ERISA) and
sections 6039D, 6047(e), 6057(b), and 6058(a) of the Internal
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Complete all entries in accordance with
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Part I Annual Report Identification Information

For the calendar plan year 2008 or fiscal plan year beginning January 01, 2008, and ending December 31, 2008

- A** This return/report is for:
- (1) ☒ a multiemployer plan; (3) ☐ a multiple-employer plan;
(2) ☐ a single-employer plan (other than a multiple-employer plan); (4) ☐ a DFE (specify)
- B** This return/report is:
- (1) ☐ the first return/report filed for the plan; (3) ☐ the final return/report filed for the plan;
(2) ☐ the amended return/report; (4) ☐ a short plan year return/report (less than 12 months).
- C** If the plan is a collectively-bargained plan, check here ☒
- D** If you filed for an extension of time to file, check the box and attach a copy of the extension application ☒

Part II Basic Plan Information - enter all requested information.

- 1a** Name of plan
OSWEGO LABORERS LOCAL 214 RETIREMENT PLAN
- 1b** Three-digit plan number (PN) 004
- 1c** Effective date of plan (mo., day, yr.)
- 2a** Plan sponsor's name and address (employer, if for a single-employer plan)
(Address should include room or suite no.)
BOARD OF TRUSTEES, LABORERS LOCAL 214 RETIREMENT PLAN
23 MTTCHESTER STREET
NWMGO NY 13126
- 2b** Employer Identification Number (EIN)
16-0876163
- 2c** Sponsor's telephone number
315-343-1666
- 2d** Business code (see instructions)
525100

Caution: A penalty for the late or incomplete filing of this return/report will be assessed unless reasonable cause is established.
Under penalties of perjury and other penalties set forth in the instructions, I declare that I have examined this return/report, including accompanying schedules, statements and attachments, and to the best of my knowledge and belief, it is true, correct, and complete.

Signature of plan administrator Date 10/11/2109 Typed or printed name of individual signing as plan administrator CINVY RA.C;TAT.T)O

Signature of employer/plan sponsor/DFE Date Typed or printed name of individual signing as employer, plan sponsor or DFE as applicable)SWEGO T.AF30RKKS LORAY, 214 RETIRK

For Paperwork Reduction Act Notice and OMB Control Numbers, see the instructions for Form 5500.

v11.3

Form 5500 (2008)

- 3a** Plan administrator's name and address (if same as plan sponsor, enter "Same")
SA14IE
- 3b** Administrator's EIN
16-0876163
- 3c** Administrator's telephone number

- 4** If the name and/or EIN of the plan sponsor has changed since the last return/report filed for this plan, enter the name, EIN and the plan number from the last return/report below:
- a** Sponsor's name **b** EIN **c** PN

5 Preparer information (optional) **a** Name (including firm name, if applicable) and address

BRAPN MILLKK COMPANY LLP TH014AS E RIT.JSY
115 SOT-AR S'RK(RET 100
S)RMACUSE 13204

b EIN

23-3060766

c Telephone no.

315-471-2777

6 Total number of participants at the beginning of the plan year

504

7 Number of participants as of the end of the plan year (welfare plans complete only lines **7a**, **7b**, **7c**, and **7d**)

a Active participants

a 103

b Retired or separated participants receiving benefits

b 269

c Other retired or separated participants entitled to future benefits

c 96

d Subtotal. Add lines **7a**, **7b**, and **7c**

d 468

e Deceased participants whose beneficiaries are receiving or are entitled to receive benefits

e 36

f Total. Add lines **7d** and **7e**

f 504

g Number of participants with account balances as of the end of the plan year (only defined contribution plans complete this item)

g

h Number of participants that terminated employment during the plan year with accrued benefits that were less than 100% vested

h

i If any participant(s) separated from service with a deferred vested benefit, enter the number of separated participants required to be reported on a Schedule SSA (Form 5500)

i 11

8 Benefits provided under the plan (complete 8a through 8c, as applicable)

a ☐ **Pension benefits** (check this box if the plan provides pension benefits and enter the applicable pension feature codes from the List of Plan Characteristics Codes (printed in the instructions)):

1B 1G - - - - -

b ☐ **Welfare benefits** (check this box if the plan provides welfare benefits and enter the applicable welfare feature codes from the List of Plan Characteristics Codes (printed in the instructions)):

- - - - -

9a Plan funding arrangement (check all that apply)

- (1) ☐ Insurance
(2) ☐ Section 412(e)(3) insurance contracts
(3) ☐ Trust
(4) ☐ General assets of the sponsor

9b Plan benefit arrangement (check all that apply)

- (1) ☐ Insurance
(2) ☐ Section 412(e)(3) insurance contracts
(3) ☐ Trust
(4) ☐ General assets of the sponsor

10 Schedules attached (Check all applicable boxes and, where indicated, enter the number attached. See instructions.)

a **Pension Benefit Schedules**

- (1) ☒ **R** (Retirement Plan Information)
(2) ☐ **OT** (Qualified Pension Plan Coverage Information)

If a Schedule T is not attached because the plan is relying on coverage testing information for a prior year, enter the year

- (3) ☒ **B** (Actuarial Information)
(4) ☐ **E** (ESOP Annual Information)
(5) ☒ **SSA** (Separated Vested participant Information)

b **Financial Schedules**

- (1) ☒ **H** (Financial Information)
(2) ☐ **I** (Financial Information – Small Plan)
(3) ☐ **0 A** (Insurance Information)
(4) ☒ **C** (Service Provider Information)
(5) ☒ **D** (DFE/Participating Plan Information)
(6) ☐ **G** (Financial Transaction Schedules)



Form 5500
Department of the Treasury
Internal Revenue Service
Department of Labor
Employee Benefits Security
Administration
Pension Benefit Guaranty Corporation

Annual Return/Report of Employee Benefit Plan

This form is required to be filed under sections 104 and 4065 of the
Employee Retirement Income Security Act of 1974 (ERISA) and
sections 6039D, 6047(e), 6057(b), and 6058(a) of the Internal
Revenue Code (the Code).

Complete all entries in accordance with
the instructions to the Form 5500.

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1210 - 0089
2008

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Part I Annual Report Identification Information

For the calendar plan year 2008 or fiscal plan year beginning July 01, 2008, and ending June 30, 2009

- A** This return/report is for:
- (1) ☒ a multiemployer plan;
- (2) ☐ a single-employer plan (other than a multiple-employer plan);
- (3) ☐ a multiple-employer plan;
- (4) ☐ a DFE (specify)
- B** This return/report is:
- (1) ☐ the first return/report filed for the plan;
- (2) ☐ the amended return/report;
- (3) ☐ the final return/report filed for the plan;
- (4) ☐ a short plan year return/report (less than 12 months).
- C** If the plan is a collectively-bargained plan, check here ☒
- D** If you filed for an extension of time to file, check the box and attach a copy of the extension application ☒

Part II Basic Plan Information - enter all requested information.

- 1a** Name of plan
- ROOFERS LOCAL 195 PENSION FUND
- 1b** Three-digit plan number (PN) 001
- 1c** Effective date of plan (mo., day, yr.)
January 01, 1105
- 2a** Plan sponsor's name and address (employer, if for a single-employer plan)
(Address should include room or suite no.)
- ROOFERS LOCAL 195 PENSION FUND
BOARN OF TRT7.QTPR.Q
6200 STATE ROTJEE 31
CICW KO NY 13039
- 2b** Employer Identification Number (EIN)
16-6158018
- 2c** Sponsor's telephone number
315-699-1388
- 2d** Business code (see instructions)
525100

Caution: A penalty for the late or incomplete filing of this return/report will be assessed unless reasonable cause is established. Under penalties of perjury and other penalties set forth in the instructions, I declare that I have examined this return/report, including accompanying schedules, statements and attachments, and to the best of my knowledge and belief, it is true, correct, and complete.

Signature of plan administrator

Date

Typed or printed name of individual signing as plan administrator

Signature of employer/plan sponsor/DFE

Date

Typed or printed name of individual signing as employer, plan sponsor or DFE as applicable

For Paperwork Reduction Act Notice and OMB Control Numbers, see the instructions for Form 5500.

v11.3

Form 5500 (2008)

3a Plan administrator's name and address (if same as plan sponsor, enter "Same")

SAME

3b Administrator's EIN

3c Administrator's telephone number

4 If the name and/or EIN of the plan sponsor has changed since the last return/report filed for this plan, enter the name, EIN and the plan number from the last return/report below:

b EIN

c PN

a Sponsor's name

5 Preparer information (optional) **a** Name (including firm name, if applicable) and address

PARENTEBEARD LLC THOMAS E. RILEY
115 SOLAR STREET 100
SYRACUSE NY 13204

b EIN

23-2932984

c Telephone no.

315-471-2777

6 Total number of participants at the beginning of the plan year

332

7 Number of participants as of the end of the plan year (welfare plans complete only lines **7a**, **7b**, **7c**, and **7d**)

a Active participants

174

b Retired or separated participants receiving benefits

108

c Other retired or separated participants entitled to future benefits

49

d Subtotal. Add lines **7a**, **7b**, and **7c**

331

e Deceased participants whose beneficiaries are receiving or are entitled to receive benefits

17

f Total. Add lines **7d** and **7e**

348

g Number of participants with account balances as of the end of the plan year (only defined contribution plans complete this item)

h Number of participants that terminated employment during the plan year with accrued benefits that were less than 100% vested

7

i If any participant(s) separated from service with a deferred vested benefit, enter the number of separated participants required to be reported on a Schedule SSA (Form 5500)

8 Benefits provided under the plan (complete **8a** through **8c**, as applicable)

a ☒ **Pension benefits** (check this box if the plan provides pension benefits and enter the applicable pension feature codes from the List of Plan Characteristics Codes (printed in the instructions)):

1B **1G** - - - - -

b ☐ **Welfare benefits** (check this box if the plan provides welfare benefits and enter the applicable welfare feature codes from the List of Plan Characteristics Codes (printed in the instructions)):

- - - - -

9a Plan funding arrangement (check all that apply)

(1) ☐ Insurance

(2) ☐ Section 412(e)(3) insurance contracts

(3) ☐ Trust

(4) ☐ General assets of the sponsor

9b Plan benefit arrangement (check all that apply)

(1) ☐ Insurance

(2) ☐ Section 412(e)(3) insurance contracts

(3) ☐ Trust

(4) ☐ General assets of the sponsor

10 Schedules attached (Check all applicable boxes and, where indicated, enter the number attached. See instructions.)

a **Pension Benefit Schedules**

(1) ☒ **R** (Retirement Plan Information)

(2) ☐ **OT** (Qualified Pension Plan Coverage Information)

If a Schedule T is not attached because the plan is relying on coverage testing information for a prior year, enter the year

(3) ☐ **B** (Actuarial Information)

(4) ☐ **E** (ESOP Annual Information)

(5) ☐ **SSA** (Separated Vested participant Information)

b **Financial Schedules**

(1) ☒ **H** (Financial Information)

(2) ☐ **I** (Financial Information – Small Plan)

(3) ☐ **0 A** (Insurance Information)

(4) ☒ **C** (Service Provider Information)

(5) ☒ **D** (DFE/Participating Plan Information)

(6) ☐ **G** (Financial Transaction Schedules)



Form 5500
Department of the Treasury
Internal Revenue Service
Department of Labor
Employee Benefits Security
Administration
Pension Benefit Guaranty Corporation

Annual Return/Report of Employee Benefit Plan

This form is required to be filed under sections 104 and 4065 of the
Employee Retirement Income Security Act of 1974 (ERISA) and
sections 6039D, 6047(e), 6057(b), and 6058(a) of the Internal
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the instructions to the Form 5500.

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Part I Annual Report Identification Information

For the calendar plan year 2008 or fiscal plan year beginning July 01, 2008, and ending June 30, 2009

- A** This return/report is for:
- (1) ☒ a multiemployer plan; (3) ☐ a multiple-employer plan;
(2) ☐ a single-employer plan (other than a multiple-employer plan); (4) ☐ a DFE (specify)
- B** This return/report is:
- (1) ☐ the first return/report filed for the plan; (3) ☐ the final return/report filed for the plan;
(2) ☐ the amended return/report; (4) ☐ a short plan year return/report (less than 12 months).

C If the plan is a collectively-bargained plan, check here ☒

D If you filed for an extension of time to file, check the box and attach a copy of the extension application ☒

Part II Basic Plan Information - enter all requested information.

1a Name of plan

ROOFERS LOCAL 195 ANNUITY FUND

1b Three-digit plan number (PN) 002

1c Effective date of plan (mo., day, yr.)
July 01, 1449

2a Plan sponsor's name and address (employer, if for a single-employer plan) (Address should include room or suite no.)

ROOFERS LOCAL 195 ANNUITY FUND
6200 STATE ROUTE 31
CICERO NY 13039-8804

2b Employer Identification Number (EIN)
14-1721374

2c Sponsor's telephone number
315-699-1388

2d Business code (see instructions)
525100

Caution: A penalty for the late or incomplete filing of this return/report will be assessed unless reasonable cause is established.

Under penalties of perjury and other penalties set forth in the instructions, I declare that I have examined this return/report, including accompanying schedules, statements and attachments, and to the best of my knowledge and belief, it is true, correct, and complete.

RL (C/ ^Q NO

Signature of plan administrator

Date

Typed or printed name of individual signing as plan administrator

Signature of employer/plan sponsor/DFE

Date

Typed or printed name of individual signing as employer, plan sponsor or DFE as applicable

For Paperwork Reduction Act Notice and OMB Control Numbers, see the instructions for Form 5500.

v11.3

Form **5500** (2008)

3a Plan administrator's name and address (if same as plan sponsor, enter "Same")

SAME

3b Administrator's EIN

3c Administrator's telephone number

4 If the name and/or EIN of the plan sponsor has changed since the last return/report filed for this plan, enter the name, EIN and the plan number from the last return/report below:

a Sponsor's name

b EIN

c PN

5 Preparer information (optional) **a** Name (including firm name, if applicable) and address

PARENTEBRARD LLC THOMAS E. RILEY
115 SOT-AR SRXEET 100
SYMACLISE 13204

b EIN

23-2932984

c Telephone no.

154712777

6 Total number of participants at the beginning of the plan year

6 327

7 Number of participants as of the end of the plan year (welfare plans complete only lines **7a**, **7b**, **7c**, and **7d**)

a Active participants

a 228

b Retired or separated participants receiving benefits

b 17

c Other retired or separated participants entitled to future benefits

c 113

d Subtotal. Add lines **7a**, **7b**, and **7c**

d 358

e Deceased participants whose beneficiaries are receiving or are entitled to receive benefits

e 2

f Total. Add lines **7d** and **7e**

f 360

g Number of participants with account balances as of the end of the plan year (only defined contribution plans complete this item)

g

h Number of participants that terminated employment during the plan year with accrued benefits that were less than 100% vested

h 13

i If any participant(s) separated from service with a deferred vested benefit, enter the number of separated participants required to be reported on a Schedule SSA (Form 5500)

i 16

8 Benefits provided under the plan (complete 8a through 8c, as applicable)

a ☐ Pension benefits (check this box if the plan provides pension benefits and enter the applicable pension feature codes from the List of Plan Characteristics Codes (printed in the instructions)):

- - - - -

b ☐ Welfare benefits (check this box if the plan provides welfare benefits and enter the applicable welfare feature codes from the List of Plan Characteristics Codes (printed in the instructions)):

- - - - -

9a Plan funding arrangement (check all that apply)

(1) ☐ Insurance

(2) ☐ Section 412(e)(3) insurance contracts

(3) ☐ Trust

(4) ☐ General assets of the sponsor

9b Plan benefit arrangement (check all that apply)

(1) ☐ Insurance

(2) ☐ Section 412(e)(3) insurance contracts

(3) ☐ Trust

(4) ☐ General assets of the sponsor

10 Schedules attached (Check all applicable boxes and, where indicated, enter the number attached. See instructions.)

a **Pension Benefit Schedules**

(1) ☐ **R** (Retirement Plan Information)

(2) ☐ **OT** (Qualified Pension Plan Coverage Information)

If a Schedule T is not attached because the plan is relying on coverage testing information for a prior year, enter the year

(3) ☐ **B** (Actuarial Information)

(4) ☐ **E** (ESOP Annual Information)

(5) ☒ **SSA** (Separated Vested participant Information)

b **Financial Schedules**

(1) ☒ **H** (Financial Information)

(2) ☐ **I** (Financial Information – Small Plan)

(3) ☒ **0 A** (Insurance Information)

(4) ☒ **C** (Service Provider Information)

(5) ☒ **D** (DFE/Participating Plan Information)

(6) ☐ **G** (Financial Transaction Schedules)



Form 5500
Department of the Treasury
Internal Revenue Service
Department of Labor
Employee Benefits Security
Administration
Pension Benefit Guaranty Corporation

Annual Return/Report of Employee Benefit Plan

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- (2) ☐ a single-employer plan (other than a multiple-employer plan);
- (3) ☐ a multiple-employer plan;
- (4) ☐ a DFE (specify)
- B** This return/report is:
- (1) ☐ the first return/report filed for the plan;
- (2) ☐ the amended return/report;
- (3) ☐ the final return/report filed for the plan;
- (4) ☐ a short plan year return/report (less than 12 months).
- C** If the plan is a collectively-bargained plan, check here ☒
- D** If you filed for an extension of time to file, check the box and attach a copy of the extension application ☒

Part II Basic Plan Information - enter all requested information.

1a Name of plan

SEIU 1199UPSTATE PENSION FUND

1b Three-digit
plan number (PN) 001

1c Effective date of plan (mo., day, yr.)
January 01, 1971

2a Plan sponsor's name and address (employer, if for a single-employer plan) (Address should include room or suite no.)

SEIU 1199UPSTATE PEN. FD BD OF TRUS
4242 RIDGE LEA ROAD, SUITE 30
AMHERST NY 14226-5122

2b Employer Identification Number (EIN)
16-1112391

2c Sponsor's telephone number
716-362-0680

2d Business code (see instructions)
622000

Caution: A penalty for the late or incomplete filing of this return/report will be assessed unless reasonable cause is established.
Under penalties of perjury and other penalties set forth in the instructions, I declare that I have examined this return/report, including accompanying schedules, statements and attachments, and to the best of my knowledge and belief, it is true, correct, and complete.

R I ,-TODO --G.WEV^

Signature of plan administrator

Date

Typed or printed name of individual signing as plan administrator

LZS,-N^A C C-O

Signature of employer/plan sponsor/DFE

Date

Typed or printed name of individual signing as employer, plan
sponsor or DFE as applicable

For Paperwork Reduction Act Notice and OMB Control Numbers, see the instructions for Form 5500.

Form 5500 (2008)

v11.3

3a Plan administrator's name and address (if same as plan sponsor, enter "Same")

TRUSTEES OF SEIU LORAT. 1199 UPSTATE PENSION FUNL
4242 RIDGE LRK ROAN SUITE 30
AMLIMRST NY 14226

3b Administrator's EIN
16-1112391

3c Administrator's telephone number
716-362-0680

4 If the name and/or EIN of the plan sponsor has changed since the last return/report filed for this plan, enter the name, EIN and the plan number from the last return/report below:

b EIN

c PN

a Sponsor's name

5 Preparer information (optional) a Name (including firm name, if applicable) and address

ARRARA & BORCZYNSKI, LLP
424 MAIN ST. 1806 LIBERTY BLDG.
BUFFALO 14202-3618

b EIN

16-1462141

c Telephone no.

116-852-6681

6 Total number of participants at the beginning of the plan year

10312

7 Number of participants as of the end of the plan year (welfare plans complete only lines 7a, 7b, 7c, and 7d)

a Active participants

5698

b Retired or separated participants receiving benefits

1587

c Other retired or separated participants entitled to future benefits

3079

d Subtotal. Add lines 7a, 7b, and 7c

10364

e Deceased participants whose beneficiaries are receiving or are entitled to receive benefits

36

f Total. Add lines 7d and 7e

10400

g Number of participants with account balances as of the end of the plan year (only defined contribution plans complete this item)

h Number of participants that terminated employment during the plan year with accrued benefits that were less than 100% vested

i If any participant(s) separated from service with a deferred vested benefit, enter the number of separated participants required to be reported on a Schedule SSA (Form 5500)

188

8 Benefits provided under the plan (complete 8a through 8c, as applicable)

a ☒ Pension benefits (check this box if the plan provides pension benefits and enter the applicable pension feature codes from the List of Plan Characteristics Codes (printed in the instructions)):

1B 1G - - - - -

b ☐ Welfare benefits (check this box if the plan provides welfare benefits and enter the applicable welfare feature codes from the List of Plan Characteristics Codes (printed in the instructions)):

- - - - -

9a Plan funding arrangement (check all that apply)

- (1) ☐ Insurance
(2) ☐ Section 412(e)(3) insurance contracts
(3) ☐ Trust
(4) ☐ General assets of the sponsor

9b Plan benefit arrangement (check all that apply)

- (1) ☐ Insurance
(2) ☐ Section 412(e)(3) insurance contracts
(3) ☐ Trust
(4) ☐ General assets of the sponsor

10 Schedules attached (Check all applicable boxes and, where indicated, enter the number attached. See instructions.)

a Pension Benefit Schedules

- (1) ☒ R (Retirement Plan Information)
(2) ☐ OT (Qualified Pension Plan Coverage Information)

If a Schedule T is not attached because the plan is relying on coverage testing information for a prior year, enter the year

- (3) ☒ B (Actuarial Information)
(4) ☐ E (ESOP Annual Information)
(5) ☒ SSA (Separated Vested participant Information)

b Financial Schedules

- (1) ☒ H (Financial Information)
(2) ☐ I (Financial Information - Small Plan)
(3) ☐ A (Insurance Information)
(4) ☒ C (Service Provider Information)
(5) ☒ D (DFE/Participating Plan Information)
(6) ☐ G (Financial Transaction Schedules)



Form 5500
Department of the Treasury
Internal Revenue Service
Department of Labor
Employee Benefits Security
Administration
Pension Benefit Guaranty Corporation

Annual Return/Report of Employee Benefit Plan

This form is required to be filed under sections 104 and 4065 of the
Employee Retirement Income Security Act of 1974 (ERISA) and
sections 6039D, 6047(e), 6057(b), and 6058(a) of the Internal
Revenue Code (the Code).

Complete all entries in accordance with
the instructions to the Form 5500.

Official Use Only
OMB Nos. 1210 - 0110
1210 - 0089
2008
This Form is Open to
Public Inspection

Part I Annual Report Identification Information

For the calendar plan year 2008 or fiscal plan year beginning January 01, 2008 , and ending December 31, 2008

- A** This return/report is for:
- (1) ☒ a multiemployer plan;
- (2) ☐ a single-employer plan (other than a multiple-employer plan);
- (3) ☐ a multiple-employer plan;
- (4) ☐ a DFE (specify)
- B** This return/report is:
- (1) ☐ the first return/report filed for the plan;
- (2) ☐ the amended return/report;
- (3) ☐ the final return/report filed for the plan;
- (4) ☐ a short plan year return/report (less than 12 months).
- C** If the plan is a collectively-bargained plan, check here ☒
- D** If you filed for an extension of time to file, check the box and attach a copy of the extension application ☒

Part II Basic Plan Information - enter all requested information.

1a Name of plan

SERVICE EMPLOYEES PENSION FD OF UPSTATE NEW YORK

1b Three-digit
plan number (PN) 001

1c Effective date of plan (mo., day, yr.)
April 29, 1965

2a Plan sponsor's name and address (employer, if for a single-employer plan) (Address should include room or suite no.)

SERVICE EMPLOYEES PENSION FUND OF UPSTATE NEW YORK
BETH BARRETT, FUND MANAGER
PO BOX 1240
SYRACUSE NY 13201-1240

2b Employer Identification Number (EIN)
16-0908576

2c Sponsor's telephone number
315-424-1754

2d Business code (see instructions)
812990

Caution: A penalty for the late or incomplete filing of this return/report will be assessed unless reasonable cause is established.
Under penalties of perjury and other penalties set forth in the instructions, I declare that I have examined this return/report, including accompanying schedules, statements and attachments, and to the best of my knowledge and belief, it is true, correct, and complete.

-EL-1W RQOZC--^^

Signature of plan administrator

Date

Typed or printed name of individual signing as plan administrator

Signature of employer/plan sponsor/DFE

Date

Typed or printed name of individual signing as employer, plan
sponsor or DFE as applicable

For Paperwork Reduction Act Notice and OMB Control Numbers, see the instructions for Form 5500.

v11.3

Form 5500 (2008)

3a Plan administrator's name and address (if same as plan sponsor, enter "Same")

SERVICE EMPL PENSION FUND OF UPSTATE NEW YORK
BETH BARRETT, FUND MANAGER
PO BOX 1240
SYRACUSE NY 13201-1240

3b Administrator's EIN
16-0908576

3c Administrator's telephone number
315-424-1754

4 If the name and/or EIN of the plan sponsor has changed since the last return/report filed for this plan, enter the name, EIN and the plan number from the last return/report below:

b EIN

c PN

a Sponsor's name

5 Preparer information (optional) a Name (including firm name, if applicable) and address

b EIN

ROBERT E. KILFOYLE, CPA
109 S WARREN ST STE 1403
SYRACUSE NY 13202-4711

c Telephone no.
315-422-4900

6 Total number of participants at the beginning of the plan year

7493

7 Number of participants as of the end of the plan year (welfare plans complete only lines 7a, 7b, 7c, and 7d)

a Active participants

4942

b Retired or separated participants receiving benefits

1065

c Other retired or separated participants entitled to future benefits

1791

d Subtotal. Add lines 7a, 7b, and 7c

7798

e Deceased participants whose beneficiaries are receiving or are entitled to receive benefits

102

f Total. Add lines 7d and 7e

7900

g Number of participants with account balances as of the end of the plan year (only defined contribution plans complete this item)

g

h Number of participants that terminated employment during the plan year with accrued benefits that were less than 100% vested

h

i If any participant(s) separated from service with a deferred vested benefit, enter the number of separated participants required to be reported on a Schedule SSA (Form 5500)

i 184

8 Benefits provided under the plan (complete 8a through 8c, as applicable)

a ☒ Pension benefits (check this box if the plan provides pension benefits and enter the applicable pension feature codes from the List of Plan Characteristics Codes (printed in the instructions)):

1B - - - - -

b ☐ Welfare benefits (check this box if the plan provides welfare benefits and enter the applicable welfare feature codes from the List of Plan Characteristics Codes (printed in the instructions)):

- - - - -

9a Plan funding arrangement (check all that apply)

- (1) ☐ Insurance
(2) ☐ Section 412(e)(3) insurance contracts
(3) ☐ Trust
(4) ☐ General assets of the sponsor

9b Plan benefit arrangement (check all that apply)

- (1) ☐ Insurance
(2) ☐ Section 412(e)(3) insurance contracts
(3) ☐ Trust
(4) ☐ General assets of the sponsor

10 Schedules attached (Check all applicable boxes and, where indicated, enter the number attached. See instructions.)

a Pension Benefit Schedules

- (1) ☒ R (Retirement Plan Information)
(2) ☐ OT (Qualified Pension Plan Coverage Information)

If a Schedule T is not attached because the plan is relying on coverage testing information for a prior year, enter the year

- (3) ☒ B (Actuarial Information)
(4) ☐ E (ESOP Annual Information)
(5) ☒ SSA (Separated Vested participant Information)

b Financial Schedules

- (1) ☒ H (Financial Information)
(2) ☐ I (Financial Information - Small Plan)
(3) ☐ A (Insurance Information)
(4) ☒ C (Service Provider Information)
(5) ☒ D (DFE/Participating Plan Information)
(6) ☐ G (Financial Transaction Schedules)



Form 5500
Department of the Treasury
Internal Revenue Service
Department of Labor
Employee Benefits Security
Administration
Pension Benefit Guaranty Corporation

Annual Return/Report of Employee Benefit Plan

This form is required to be filed under sections 104 and 4065 of the
Employee Retirement Income Security Act of 1974 (ERISA) and
sections 6039D, 6047(e), 6057(b), and 6058(a) of the Internal
Revenue Code (the Code).

Complete all entries in accordance with
the instructions to the Form 5500.

Official Use Only
OMB Nos. 1210 - 0110
1210 - 0089
2008
This Form is Open to
Public Inspection

Part I Annual Report Identification Information

For the calendar plan year 2008 or fiscal plan year beginning January 01, 2008, and ending December 31, 2008

- A** This return/report is for:
- (1) ☐ a multiemployer plan; (3) ☐ a multiple-employer plan;
(2) ☒ a single-employer plan (other than a multiple-employer plan); (4) ☐ a DFE (specify)
- B** This return/report is:
- (1) ☐ the first return/report filed for the plan; (3) ☐ the final return/report filed for the plan;
(2) ☐ the amended return/report; (4) ☐ a short plan year return/report (less than 12 months).
- C** If the plan is a collectively-bargained plan, check here ☐
- D** If you filed for an extension of time to file, check the box and attach a copy of the extension application ☐

Part II Basic Plan Information - enter all requested information.

- 1a** Name of plan
SYRACUSE BUILDERS EXCHANGE, INC. / CEA PENSION PLAN
- 1b** Three-digit plan number (PN) 001
- 1c** Effective date of plan (mo., day, yr.)
January 01, 1982
- 2a** Plan sponsor's name and address (employer, if for a single-employer plan)
(Address should include room or suite no.)
SYRACUSE BUILDERS EXCHANGE, INC.
6563 RIDINGS ROAD
SYRACUSE NY 13206-1202
- 2b** Employer Identification Number (EIN)
15-0464360
- 2c** Sponsor's telephone number
315-437-9936
- 2d** Business code (see instructions)
238900

Caution: A penalty for the late or incomplete filing of this return/report will be assessed unless reasonable cause is established. Under penalties of perjury and other penalties set forth in the instructions, I declare that I have examined this return/report, including accompanying schedules, statements and attachments, and to the best of my knowledge and belief, it is true, correct, and complete.

Signature of plan administrator Date Typed or printed name of individual signing as plan administrator
EARL N. HALL

Signature of employer/plan sponsor/DFE Date Typed or printed name of individual signing as employer, plan sponsor or DFE as applicable
EARL N. HALL

For Paperwork Reduction Act Notice and OMB Control Numbers, see the instructions for Form 5500.

v11.3

3a Plan administrator's name and address (if same as plan sponsor, enter "Same")

SAME

3b Administrator's EIN

3c Administrator's telephone number

4 If the name and/or EIN of the plan sponsor has changed since the last return/report filed for this plan, enter the name, EIN and the plan number from the last return/report below:

b EIN

a Sponsor's name

c PN

5 Preparer information (optional)		a Name (including firm name, if applicable) and address	b EIN	c Telephone no.
6	Total number of participants at the beginning of the plan year		6	14
7	Number of participants as of the end of the plan year (welfare plans complete only lines 7a, 7b, 7c, and 7d)			
a	Active participants		a	15
b	Retired or separated participants receiving benefits		b	
c	Other retired or separated participants entitled to future benefits		c	
d	Subtotal. Add lines 7a, 7b, and 7c		d	15
e	Deceased participants whose beneficiaries are receiving or are entitled to receive benefits		e	
f	Total. Add lines 7d and 7e		f	15
g	Number of participants with account balances as of the end of the plan year (only defined contribution plans complete this item)		g	15
h	Number of participants that terminated employment during the plan year with accrued benefits that were less than 100% vested		h	
i	If any participant(s) separated from service with a deferred vested benefit, enter the number of separated participants required to be reported on a Schedule SSA (Form 5500)		i	
8	Benefits provided under the plan (complete 8a through 8c, as applicable)			
a	<input checked="" type="checkbox"/> Pension benefits (check this box if the plan provides pension benefits and enter the applicable pension feature codes from the List of Plan Characteristics Codes (printed in the instructions)):			
		2E	2J	- - - - -
b	<input type="checkbox"/> Welfare benefits (check this box if the plan provides welfare benefits and enter the applicable welfare feature codes from the List of Plan Characteristics Codes (printed in the instructions)):			
		-	-	- - - - -
9a	Plan funding arrangement (check all that apply)		9b	Plan benefit arrangement (check all that apply)
(1)	<input type="checkbox"/> Insurance		(1)	<input type="checkbox"/> Insurance
(2)	<input type="checkbox"/> Section 412(e)(3) insurance contracts		(2)	<input type="checkbox"/> Section 412(e)(3) insurance contracts
(3)	<input type="checkbox"/> Trust		(3)	<input type="checkbox"/> Trust
(4)	<input type="checkbox"/> General assets of the sponsor		(4)	<input type="checkbox"/> General assets of the sponsor
10	Schedules attached (Check all applicable boxes and, where indicated, enter the number attached. See instructions.)			
a	Pension Benefit Schedules		b	Financial Schedules
(1)	<input checked="" type="checkbox"/> R (Retirement Plan Information)		(1)	<input type="checkbox"/> H (Financial Information)
(2)	<input type="checkbox"/> T (Qualified Pension Plan Coverage Information)		(2)	<input checked="" type="checkbox"/> I (Financial Information - Small Plan)
	If a Schedule T is not attached because the plan is relying on coverage testing information for a prior year, enter the year		(3)	<input type="checkbox"/> A (Insurance Information)
(3)	<input type="checkbox"/> B (Actuarial Information)		(4)	<input type="checkbox"/> C (Service Provider Information)
(4)	<input type="checkbox"/> E (ESOP Annual Information)		(5)	<input type="checkbox"/> D (DFE/Participating Plan Information)
(5)	<input type="checkbox"/> SSA (Separated Vested participant Information)		(6)	<input type="checkbox"/> G (Financial Transaction Schedules)